HGB Payroll, Inc.

Employer Information Form

Employer Name:		DBA Name:	

Main location mailing:

Address:		City:		State:		Zip Code:	

Contact Information:

Phone:		Fax:		Website:	

Owner:		Title:		Phone:		Email:	

Admin:		Title:		Phone:		Email:	

Waiting Period:	☐ 30 days ☐ 60 days	☐ 90 days ☐ None	Full-time Requirement: (20 to 40 hours)

Employer Contributions: All Full-Time employees are required to participate in the Plan.

Employee Only	Employee + Spouse	Employee + Children	Full Family

Number of Owners:	

Medical Enrollments:

Employee Only:		Employee + Spouse:		Employee + Children:		Full Family:	

Ancillary Products: (please check benefits offered)

Dental ☐	Vision ☐	Life ☐	Vol Life ☐	STD ☐	LTD ☐
Vol STD ☐	Vol LTD ☐	Individual Disability ☐	Accident ☐	Hospital ☐	401(k) ☐

<u>In addition to this form, please send us a copy of your most recent invoice</u>

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