# Employee Benefits

EMPLOYER APPLICATION
Osprey Health

Company Name ______________________ Date: ______________

Address: ______________________ Phone: ______________

*Street address* *Apt/Unit #*

______________________ Email: ______________

*City* *State* *Zip Code*

Effective Date ______________ Tax ID/ EIN ______________ SIC Code: ______________

Company Contact: ______________ Email: ______________ Phone: ______________

| | | | | |
|---|---|---|---|---|
| Are you interested in offering medical plans? | Yes ☐ | No ☐ | ER Paid ______________ | Voluntary ______________ |
| Are you interested in offering Dental & Vision plans? | Yes ☐ | No ☐ | ER Paid ______________ | Voluntary ______________ |
| Are you interested in offering Ancillary Plans? | Yes ■ | No ☐ | All Lines of Coverage? | ______________ |
| Are you interested in offering Legal, ID Theft and Financial Wellness? | Yes ☐ | No ■ | All Lines of Coverage? | ______________ |

Number of pay periods 24/26/52 ______________ Date of the first pay of the year: ______________

OSPREY
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## Disclaimer and signature

I certify that my answers are true and complete to the best of my knowledge. If this application leads to enrollment in insurance policies, I understand that false or misleading information in my application my terminate coverage.

Signature: ______________________ Date: ______________

A Full and Complete census must be submitted to osprey for enrollment, click here for link to our Census