

Confidential Questionnaire

RETIREMENT PLAN & EMPLOYEE BENEFITS FACT FINDER

"Your One-Stop Solution for Comprehensive Benefits Planning"

Please provide me a proposal regarding (check all that apply):

401(k) and Profit Sharing

- Micro(k)[®] (Owners/Partners Only)
- 401(k) Profit Sharing
- DASH 401(k)
- Profit Sharing (Stand Alone)

Defined Benefit

- 430(d)
- "Fully Insured" 412(e)(3)
- Cash Balance

Group Insurance

- Life Insurance
- Long-Term Disability
- Short-Term Disability
- NY Disability Benefits Law (DBL)
- NJ Temporary Disability Benefits (TBD)

Worksite

- Accident
- Whole Life
- Universal Life
- Short-Term Disability

RETIREMENT PLAN DESIGN

HOME OFFICE

855-861-1584 (Ext. 7337 or 7317)

Fax 607-773-2007

E-mail: qplans@smlny.com

NYC METRO AREA

212-268-9440

E-mail: rnovak@smlny.com

GROUP BENEFIT SOLUTIONS

800-927-8846

Fax: 607-722-5622

E-mail: groupquote@smlny.com

TRADITIONAL WORKSITE SOLUTIONS

800-346-7171 (Ext. 7741)

Fax: 607-723-5651

E-mail: kmohney@smlny.com



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For more retirement information visit www.smlplans.com

By completing this questionnaire you understand and acknowledge that by either not fully or accurately completing this questionnaire, any design study provided may be inappropriate to the needs and objectives of the client.

PROPOSAL CENSUS DATA

Listing of All Employees of Organization(s)

First Name	Last Name	Sex	Birth Date M / D / Y ¹	Hire Date M / D / Y ²	Percent Owned	W2 Compensation	Schedule C or K1 Income ³	Annual Hours Worked If Part Time	Insurance: PP=Pref. Plus P=Preferred N=Nonsmoker PS=Pref. Smoker S=Smoker SPNS=Standard Plus Nonsmoker ⁴	Family Member of Owner? ⁵	Job Description or Exclude from Group ⁶

¹Dates of birth should be listed, not ages.
²Date of hire will determine eligibility.
³Non-incorporated business owners do not receive W2 wages; they receive a Schedule C or K1 Distribution. S Corp. owners and some LLC members receive both W2 and K1; each should be entered here. Make sure that income entered in this column is accurate and can be documented.
⁴Only available for select products.
⁵A spouse or linear family member of a 5 percent owner affects plan testing and group insurance “carve-out” plans—enter the relationship to the owner (e.g., spouse, son, etc.)
⁶Use this column to convey notes for “carve-out” plans or other important information you want to share; otherwise you may leave this blank.

CONFIDENTIAL FACT FINDER

I. EMPLOYER INFORMATION (Required for All)

A. Company Name _____ City and State _____

B. Calendar Year End Fiscal Year End: _____
mm/dd/yy

C. Number of Employees _____ Union Yes No

D. Type of Organization:

Corporation	Non-Incorporated	LLC or Other
<input type="checkbox"/> Regular "C"	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Taxed as Partnership
<input type="checkbox"/> S Corporation	<input type="checkbox"/> Partnership or LLP	<input type="checkbox"/> Taxed as Corporation

E. The owners, officers and key personnel of the Employer are:

Name	Title	Percent Owned
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. AGENT/PLANNER INFORMATION

A. Agent or Planner Name: _____

B. Phone: _____ Email Address: _____

C. General Agent (if different): _____ Not yet contracted with SML

D. Broker Dealer: _____ Not a Registered Representative

E. Additional Comments: _____

III. RETIREMENT PLAN DESIGN

A. Regarding controlled or affiliated service groups, please complete the summary below if there are any affirmative answers to the following questions:

1. Do the key personnel own any part of or operate any other trades or businesses?
2. Are the revenues of the employer directly generated by businesses with any common ownership?
3. Are major job-related functions performed by leased employees or by employees of a separate business?

Related Companies	Owner's Name	Percent Owned
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

III. RETIREMENT PLAN DESIGN (continued)

B. Does the employer or any related employer sponsor a qualified retirement plan? If so, complete the summary below and submit a copy of the Summary Plan Description (SPD) if available:

Type of Plan

Plan Formula

- Leave in place Terminate Modify

C. What are the goals of the new plan? (check all that apply)

401(k)/Profit Sharing

Defined Benefit/"Fully Insured"

- | | |
|--|---|
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> Large Employer Contributions |
| <input type="checkbox"/> Employee Participation (Salary Deferrals) | <input type="checkbox"/> Maximize Retirement Benefits |
| <input type="checkbox"/> Broad Investment Array | <input type="checkbox"/> Stable or Guaranteed Investments |

D. What is the Employer's Budget: \$ _____ or _____ % of the payroll

E. Who are the Preferred/Favored Participants: _____

F. Does the Employer understand the Benefits of Life Insurance in the Plan? _____

G. Life Insurance Needs: _____

IV. GROUP INSURANCE

A. Industry Description or SIC Code*: _____

B. Group Benefit(s) (available in most states for 2 or more non-related lives):

1. **Group Life** Flat Amount \$ _____ Percent of Income 1X 2X Other _____

2. **Short-Term Disability (STD)**

Percent of Income 50% 60% 66 2/3% Flat Amount \$ _____

Elimination Period 0/7 7/7 0/14 14/14 30/30

Benefit Period 13 Weeks 26 Weeks 52 Weeks

3. **Long-Term Disability (LTD)**

Percent of Income 60% Maximum Available

Elimination Period 90 Days 180 Days

Benefit Period 2 Year 5 Year Age 65

C. For all three coverages, is coverage currently in force? Yes No

D. Is any requested coverage replacing similar coverage? Yes No If Yes: Life STD LTD

E. Will the employees be contributing to the cost of the insurance? Yes No

If Yes: Life and AD&D _____% Dependent Life _____% STD _____% LTD _____%

V. WORKSITE

A. Industry Description or SIC Code*: _____

B. Worksite Benefit(s) (available in most states for 10 lives or more):

1. Accident Yes No

2. Whole Life Yes No

3. Universal Life Yes No

4. Voluntary Short Term DI Yes No

If Yes: **Benefit Period**

3 Months 6 Months 1 Year 2 Year

Elimination Period

0/7 7/7 0/14 14/14 30/30

* To determine if industry is eligible for benefits, call: 800-927-8846 (Group) or 800-346-7171 (Worksite)