# Employer Partnership
## Onboarding Form

avant & intellicents

### section 1 - advisor contact information

| | |
|---|---|
| Advisor Name | Office Address |
| Advisor Phone | Website |
| Advisor Email | |

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### section 2 - employer information

company details

| |
|---|
| Legal Company Name |
| DBA / Trade Name *(if any)* |
| Primary Business Address |
| Employer Identification # |
| Total # of Employees |
| Estimated # of Employees 63+ |
| Industry / Sector |

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primary HR / benefits contact

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|---|
| Contact Name |
| Title |
| Phone |
| Email |
| Preferred Contact Method |

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## section 3 - data & element requests

### employee census

*Provide an employee census file including the fields below. A standard spreadsheet (Excel or CSV) is preferred.*

- [ ] Employee First and Last Name
- [ ] Date of Birth
- [ ] Home Address
- [ ] Employee Email Address
- [ ] Employee Phone Number
- [ ] Employment Status *(full-time / part-time)*
- [ ] Current Enrollment in Employer Health Plan *(Yes / No)*
- [ ] Current Plan Election *(if multiple options)*
- [ ] Spouse / Dependent Coverage *(Yes / No)*

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### employee census

*Required to create co-branded employee-facing materials. High-resolution files preferred.*

- [ ] Company Logo *(vector (SVG or EPS) or high resolution PNG; send files to your advisor)*
- [ ] Primary and Secondary Brand Colors *(HEX, RGB, or CMYK values preferred)*
- [ ] Brand / Style Guidelines *(if available; optional but recommended)*
- [ ] Approval Contact for Co-Branded Materials *(name & email of person who signs off on designs)*

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### benefit renewal date

Current Benefit Plan Year Start

Benefit Renewal / Anniversary Date

Open Enrollment Window

Benefits Broker / Consultant *(if any)*

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## current carrier information

*Please provide details on your existing group health and ancillary benefit carriers.*

| Coverage Type | Carrier / Insurance Company | Plan Name(s) or Group Number |
|---|---|---|
| Medical / Major Medical | | |
| Dental | | |
| Vision | | |
| Life / AD&D | | |
| Supplemental / Voluntary | | |

## plan documents & benefits guide

*Please provide the following documents to help us understand your current benefit offerings.*

- ☐ Current Medical Plan Design / Summary of Benefits and Coverage (SBC) *(one document per plan offered)*
- ☐ Employee Benefits Guide or Benefits Summary Booklet *(most recent plan year)*
- ☐ Carrier Contact / Member Services Information *(phone numbers and web portals for employees)*

Is your current medical prescription drug coverage creditable *(as good as Medicare Part D)*?

☐ Yes *(creditable)* ☐ No / Unsure

## acknowledgement & submission

*Please complete and return this form to your advisor. Once received, we will schedule your kickoff call within 2 business days.*

Authorized Employer Signature _____ Date _____

Printed Name & Title _____ Advisor Signature _____