

PLEASE COMPLETE THIS FORM IF THIS FIRM/ORGANIZATION OFFERED HEALTH INSURANCE TO ANY EMPLOYEE ON 10/01/2002.

- YOU MAY SUBMIT YOUR ANSWERS ON-LINE AT WWW.GAEMPLOYERSURVEY.ORG, FAX THE COMPLETED FORM TO (404) 463-9677 OR RETURN IT IN THE ENCLOSED POSTAGE PAID ENVELOPE.
- IN ALL YOUR RESPONSES, PLEASE PROVIDE THE BEST INFORMATION YOU HAVE AVAILABLE. IF YOU DO NOT KNOW THE ANSWER TO A PARTICULAR QUESTION, PLEASE PROVIDE YOUR BEST ESTIMATE. IF YOU NEED ASSISTANCE, PLEASE CONTACT JEAN O'CONNOR AT (404) 656-7504.

1. HOW MANY EMPLOYEES, INCLUDING FULL-TIME, PART-TIME, CONTRACT, TEMPORARY AND SEASONAL WORKERS, WORKED FOR YOUR FIRM OR ORGANIZATION DURING THE PAY PERIOD THAT INCLUDED 10/1/2002? _____ (INCLUDE ALL EMPLOYEES IN ALL GEORGIA ESTABLISHMENTS OR LOCATIONS FOR WHICH THIS OFFICE ADMINISTERS BENEFITS AND PAYROLL.)

2. HOW MANY OF THESE EMPLOYEES ARE: PERMANENT FULL-TIME? _____ PERMANENT PART-TIME? _____.

3. HOW MANY HOURS PER WEEK MUST AN EMPLOYEE WORK TO BE CONSIDERED FULL-TIME? _____ / HOURS PER WEEK

4. OF THE PERMANENT FULL-TIME EMPLOYEES WORKING FOR YOUR FIRM / ORGANIZATION ON 10/1/2002:

WHAT PERCENTAGE WERE ELIGIBLE UNDER ANY OF YOUR FIRM / ORGANIZATION'S HEALTH BENEFIT PLANS? _____%

WHAT PERCENTAGE WERE ENROLLED ON 10/1/2002 UNDER ANY OF YOUR FIRM / ORGANIZATION'S HEALTH BENEFIT PLANS? _____%

5. IN YOUR FIRM / ORGANIZATION, ARE THE FOLLOWING KINDS OF WORKERS ALSO ELIGIBLE TO PARTICIPATE IN THE HEALTH BENEFIT PLAN?

	YES	NO	NO SUCH EMPLOYEES
PART-TIME PERMANENT EMPLOYEES	قا	قا	قا
TEMPORARY EMPLOYEES	قا	قا	قا
HOURLY EMPLOYEES	قا	قا	قا
SEASONAL EMPLOYEES	قا	قا	قا
EMPLOYEES WHO ARE UNION MEMBERS	قا	قا	قا

6. HOW MANY DAYS AFTER HIRE MUST AN EMPLOYEE WORK FOR YOUR FIRM/ORGANIZATION TO BE ELIGIBLE FOR HEALTH BENEFITS? (PLEASE PUT ZERO IF NONE) _____ (DAYS)

7. WHAT TYPES OF HEALTH BENEFIT PLANS DOES YOUR FIRM/ORGANIZATION OFFER? (CHECK ALL THAT APPLY)

- HEALTH MAINTENANCE ORGANIZATION (HMO)
- PREFERRED PROVIDER ORGANIZATION (PPO)
- TRADITIONAL INDEMNITY PLAN
- HIGH DEDUCTIBLE PLAN (INDIVIDUAL ANNUAL DEDUCTIBLE OF \$2,000 OR HIGHER)
- MEDICAL SAVINGS ACCOUNT
- VOUCHER/ALLOWANCE FOR PURCHASE OF INDIVIDUAL PLAN
- SPECIFIC DISEASE POLICIES (FOR EXAMPLE: CANCER CARE PLAN)
- DISCOUNT PLANS (FOR EXAMPLE: DISCOUNT ON PRESCRIPTIONS)
- OTHER (SPECIFY _____)

8. WHAT IS THE FUNDING ARRANGEMENT FOR YOUR PLAN? (IF MULTIPLE PLANS, CONSIDER THE PLAN ELECTED BY THE LARGEST % OF EMPLOYEES.)

- FULLY INSURED PLAN WITH A LICENSED INSURANCE COMPANY
- SELF-INSURED PLAN (INSURANCE COMPANY MAY ADMINISTER)
- EMPLOYEES COVERED THROUGH EMPLOYEE ASSOCIATION OR UNION PLAN

9. DO EMPLOYEES HAVE A CHOICE OF MORE THAN ONE HEALTH PLAN? قا YES قا NO

10. WHAT TYPES OF BENEFITS ARE COVERED UNDER ANY OF YOUR HEALTH BENEFIT PLANS?

	OFFERED TO FULL-TIME PERMANENT EMPLOYEES		OFFERED TO DEPENDENTS	
	YES	NO	YES	NO
HOSPITAL STAYS	قا	قا	قا	قا
EMERGENCY CARE	قا	قا	قا	قا
PREVENTIVE CARE VISITS OR SCREENINGS	قا	قا	قا	قا
PRESCRIPTION DRUGS	قا	قا	قا	قا
MENTAL HEALTH CARE	قا	قا	قا	قا
DENTAL CARE	قا	قا	قا	قا
EYE CARE	قا	قا	قا	قا

11. PLEASE COMPLETE THE FOLLOWING TABLE FOR YOUR HEALTH PLAN: (IF MULTIPLE PLANS, CONSIDER THE PLAN ELECTED BY THE LARGEST % OF EMPLOYEES.)

	EMPLOYEE CONTRIBUTION	TOTAL MONTHLY COST PER EMPLOYEE
INDIVIDUAL EMPLOYEE COVERAGE	\$ _____	\$ _____
EMPLOYEE PLUS SPOUSE COVERAGE	\$ _____	\$ _____
FAMILY COVERAGE	\$ _____	\$ _____

12. CONSIDERING ALL EMPLOYER AND EMPLOYEE PREMIUM CONTRIBUTIONS, HOW MUCH DID YOUR FIRM / ORGANIZATION SPEND IN TOTAL ON HEALTH INSURANCE FOR ALL EMPLOYEES AND DEPENDENTS FOR THE MOST RECENT FULL PLAN YEAR? _____

13. COMPARED TO THE MOST RECENT FULL PLAN YEAR, HOW WOULD YOU DESCRIBE YOUR FIRM/ORGANIZATION'S HEALTH INSURANCE PREMIUMS FOR THE CURRENT PLAN YEAR?

- COSTS DECREASED COSTS INCREASED UNCHANGED NOT APPLICABLE

14. COMPARED WITH THE LAST COMPLETED PLAN YEAR, HOW HAVE YOUR FIRM / ORGANIZATION'S HEALTH BENEFITS CHANGED IN THE CURRENT YEAR? (IF MULTIPLE PLANS, CONSIDER THE PLAN ELECTED BY THE LARGEST % OF EMPLOYEES.)

	INCREASED	DECREASED	NO CHANGE	NO INSURANCE IN PREVIOUS PLAN YEAR
CO-PAYMENTS OR COINSURANCE	ف	ف	ف	ف
DEDUCTIBLES	ف	ف	ف	ف
COVERED SERVICES	ف	ف	ف	ف
CHOICE OF PROVIDERS	ف	ف	ف	ف
SHARE OF PREMIUM PAID BY EMPLOYEE FOR EMPLOYEE -ONLY COVERAGE	ف	ف	ف	ف
SHARE OF PREMIUM PAID BY EMPLOYEE FOR DEPENDENT COVERAGE	ف	ف	ف	ف

15. HOW MANY TIMES HAS YOUR FIRM / ORGANIZATION CHANGED HEALTH INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR DURING THE LAST FIVE YEARS? (IF MULTIPLE PLANS, CONSIDER THE PLAN ELECTED BY THE LARGEST % OF EMPLOYEES.) _____ (0 IF NEVER OR IF FIRST PLAN YEAR)

16. HOW LONG HAS YOUR FIRM/ORGANIZATION EXISTED? _____ YEARS.

17. HOW MANY YEARS OUT OF THE LAST 10 YEARS HAS YOUR FIRM/ORGANIZATION OFFERED HEALTH INSURANCE TO ANY EMPLOYEE(S)? _____ YEARS.

18. DOES YOUR FIRM/ORGANIZATION OFFER ANY OF THE FOLLOWING BENEFITS TO FULL-TIME PERMANENT EMPLOYEES? (CHECK ALL THAT APPLY)

- | | | |
|--|--|--|
| <input type="checkbox"/> RETIREMENT PLAN | <input type="checkbox"/> LONG TERM CARE INSURANCE | <input type="checkbox"/> PAID HOLIDAYS |
| <input type="checkbox"/> RETIREE HEALTH INSURANCE | <input type="checkbox"/> LIFE INSURANCE | <input type="checkbox"/> PAID SICK LEAVE |
| <input type="checkbox"/> TAX DEFERRED SAVINGS PLANS | <input type="checkbox"/> CHILD CARE ASSISTANCE | |
| <input type="checkbox"/> EDUCATIONAL/ TUITION ASSISTANCE | <input type="checkbox"/> FLEXIBLE WORK SCHEDULE | |
| <input type="checkbox"/> LONG TERM DISABILITY INSURANCE | <input type="checkbox"/> EMPLOYEE ASSISTANCE PROGRAM | |
| <input type="checkbox"/> SHORT TERM DISABILITY INSURANCE | <input type="checkbox"/> PAID VACATION | |

19. WHAT PERCENTAGE OF YOUR FULL-TIME PERMANENT EMPLOYEES ARE FEMALE? _____%

20. WHAT PERCENTAGE OF YOUR FULL-TIME PERMANENT EMPLOYEES HAVE BEEN EMPLOYED AT YOUR FIRM/ORGANIZATION FOR:

_____ % LESS THAN 1 YEAR _____ % FROM 1 TO 5 YEARS _____ % MORE THAN 5 YEARS

21. WHAT PERCENTAGE OF YOUR FULL-TIME PERMANENT EMPLOYEES ARE:

_____ % AGE 24 AND UNDER _____ % 25-54 YEARS OF AGE _____ % 55-64 YEARS OF AGE _____ % AGE 65 AND OVER

22. WHAT PERCENTAGE OF YOUR FULL-TIME PERMANENT EMPLOYEES EARN:

_____ % LESS THAN \$9 PER HOUR (OR ABOUT \$18,000 PER YEAR)
 _____ % BETWEEN \$9 AND \$21 PER HOUR (OR BETWEEN \$18,000 AND \$42,000)
 _____ % MORE THAN \$21 PER HOUR (OR MORE THAN \$42,000 PER YEAR)

23. WHAT PERCENTAGE OF YOUR FULL-TIME PERMANENT EMPLOYEES ARE:

_____ % CAUCASIAN _____ % AFRICAN AMERICAN _____ % LATINO OR HISPANIC
 _____ % ASIAN _____ % NATIVE AMERICAN _____ % OTHER