

PLEASE COMPLETE THIS FORM IF THIS FIRM/ORGANIZATION **OFFERED HEALTH INSURANCE** TO ANY EMPLOYEE ON 10/01/2004.

- YOU MAY SUBMIT YOUR ANSWERS ON-LINE AT WWW.GAEMPLOYERSURVEY.ORG 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 THE GSU RESEARCHERS AT 404-463-9562

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 10/1/2004? _____ (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 10/1/2004:

HOW MANY WERE ELIGIBLE UNDER ANY OF YOUR FIRM / ORGANIZATION'S HEALTH BENEFIT PLANS? _____

HOW MANY WERE ENROLLED ON 10/1/2004 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	ف	ف	ف
TEMPORARY OR SEASONAL EMPLOYEES	ف	ف	ف
HOURLY EMPLOYEES	ف	ف	ف
EMPLOYEES WHO ARE UNION MEMBERS	ف	ف	ف

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? (COMPLETE ALL THAT APPLY. IF YOU OFFER MORE THAN ONE OF ANY SINGLE PLAN TYPE, ANSWER ~~THE PLAN DESIGN PORTION~~ WITH RESPECT TO THE LARGEST PLAN)

<input type="checkbox"/>	HEALTH MAINTENANCE ORGANIZATION (HMO)	WHAT IS THE COPAYMENT FOR AN OFFICE VISIT? \$ _____
<input type="checkbox"/>	PREFERRED PROVIDER ORGANIZATION (PPO)	WHAT IS THE COPAYMENT FOR AN OFFICE VISIT: IN-NETWORK \$ _____ OUT-OF-NETWORK \$ _____
<input type="checkbox"/>	TRADITIONAL INDEMNITY PLAN	WHAT IS THE ANNUAL PER PERSON DEDUCTIBLE \$ _____
<input type="checkbox"/>	HIGH DEDUCTIBLE PLAN WITH A HEALTH SPENDING ACCOUNT	WHAT IS THE ANNUAL PER PERSON DEDUCTIBLE \$ _____
<input type="checkbox"/>	OTHER (DESCRIBE) :	

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

8. IS YOUR PLAN ADMINISTERED BY A THIRD PARTY ADMINISTRATOR (TPA) OR UNDER AN ADMINISTRATIVE SERVICES ONLY (ASO) CONTRACT?
 YES NO DO NOT KNOW

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

- | | | |
|---------------------------------------------------------------|---------------------------------------------|--------------------------------------|
| <input type="checkbox"/> PREVENTIVE CARE VISITS OR SCREENINGS | <input type="checkbox"/> PRESCRIPTION DRUGS | <input type="checkbox"/> DENTAL CARE |
| | <input type="checkbox"/> MENTAL HEALTH CARE | <input type="checkbox"/> EYE CARE |

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

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

THIS TABLE REFERS TO A PLAN THAT IS A: HMO PPO TRADITIONAL INDEMNITY HIGH DEDUCTIBLE

Please Complete Both Sides

11. WHAT IS THE TOTAL DOLLAR AMOUNT (NOT PER EMPLOYEE) SPENT BY YOUR FIRM / ORGANIZATION ON HEALTH INSURANCE FOR ALL EMPLOYEES AND DEPENDENTS FOR THE MOST RECENT FULL PLAN YEAR? _____
12. 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

13. 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 OR 1 ST YEAR OFFERED
CO-PAYMENTS OR COINSURANCE	ف	ف	ف
DEDUCTIBLES	ف	ف	ف
COVERED SERVICES	ف	ف	ف
CHOICE OF PROVIDERS	ف	ف	ف
SHARE OF PREMIUM PAID BY EMPLOYEE FOR EMPLOYEE - ONLY COVERAGE	ف	ف	ف
SHARE OF PREMIUM PAID BY EMPLOYEE FOR DEPENDENT COVERAGE	ف	ف	ف

14. 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)

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

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

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

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. FOR LARGE FIRMS IT MAY BE NECESSARY TO PROVIDE ESTIMATES.

18. HOW MANY OF YOUR FULL-TIME PERMANENT EMPLOYEES ARE FEMALE? _____

19. HOW MANY 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

20. HOW MANY 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

21. HOW MANY 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)

THANK YOU VERY MUCH FOR COMPLETING THIS IMPORTANT SURVEY. THE INFORMATION YOU HAVE PROVIDED WILL BE KEPT CONFIDENTIAL.

Please Complete Both Sides