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	☐	☐	☐
TEMPORARY OR SEASONAL EMPLOYEES	☐	☐	☐
HOURLY EMPLOYEES	☐	☐	☐
EMPLOYEES WHO ARE UNION MEMBERS	☐	☐	☐

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 PLA~~Y~~N TYPE, ANSWER ~~THE PLAN DESIGN PORTION~~ WITH RESPECT TO THE LARGEST PLAN)*

☐	HEALTH MAINTENANCE ORGANIZATION (HMO)	WHAT IS THE COPAYMENT FOR AN OFFICE VISIT? $_____
☐	PREFERRED PROVIDER ORGANIZATION (PPO)	WHAT IS THE COPAYMENT FOR AN OFFICE VISIT: IN- NETWORK $_____ OUT-OF-NETWORK $_____
☐	TRADITIONAL INDEMNITY PLAN	WHAT IS THE ANNUAL PER PERSON DEDUCTIBLE $_____
☐	HIGH DEDUCTIBLE PLAN WITH A HEALTH SPENDING ACCOUNT	WHAT IS THE ANNUAL PER PERSON DEDUCTIBLE $_____
☐	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?**
   - ☐ PREVENTIVE CARE VISITS OR SCREENINGS
   - ☐ PRESCRIPTION DRUGS
   - ☐ MENTAL HEALTH CARE
   - ☐ DENTAL CARE
   - ☐ 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 1ST YEAR OFFERED
CO-PAYMENTS OR COINSURANCE	☐	☐	☐
DEDUCTIBLES	☐	☐	☐
COVERED SERVICES	☐	☐	☐
CHOICE OF PROVIDERS	☐	☐	☐
SHARE OF PREMIUM PAID BY EMPLOYEE FOR EMPLOYEE – ONLY COVERAGE	☐	☐	☐
SHARE OF PREMIUM PAID BY EMPLOYEE FOR DEPENDENT COVERAGE	☐	☐	☐

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)

- ☐ RETIREMENT PLAN
- ☐ RETIREE HEALTH INSURANCE
- ☐ TAX DEFERRED SAVINGS PLANS
- ☐ EDUCATIONAL/ TUITION ASSISTANCE
- ☐ LONG TERM DISABILITY INSURANCE
- ☐ SHORT TERM DISABILITY INSURANCE
- ☐ LONG TERM CARE INSURANCE
- ☐ LIFE INSURANCE
- ☐ CHILD CARE ASSISTANCE
- ☐ FLEXIBLE WORK SCHEDULE
- ☐ EMPLOYEE ASSISTANCE PROGRAM
- ☐ PAID VACATION
- ☐ PAID HOLIDAYS
- ☐ PAID SICK LEAVE

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-T~~-~~IME 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