



**Business Profile Worksheet**

**PEO NEEDS ASSESSMENT**

Contact Information

Company Name: \_\_\_\_\_ website: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_ e-mail: \_\_\_\_\_

Decision Maker: \_\_\_\_\_ Title: \_\_\_\_\_ e-mail: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Company Operations**

Years in business: \_\_\_\_\_ Type of business: \_\_\_\_\_ SIC code(s): \_\_\_\_\_

Number of Employees: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Total Payroll \_\_\_\_\_ Time Clock Y/N

Present Pay Cycle: \_\_\_\_\_ Est Cost of Payroll Admin \_\_\_\_\_ FEIN(s) \_\_\_\_\_

Employee Benefits (circle which apply) Medical, Dental, Vision, Life, LTD, STD, Ret Plans (describe)  
\_\_\_\_\_

Employer Contributions, if any (by plan) \_\_\_\_\_ Section 125 - Y/N

FSA Medical Limit \$ \_\_\_\_\_ FSA Dependent Care – Y/N

Employment Practices Liability Insurance –Y/N Limit \_\_\_\_\_ Deductible \_\_\_\_\_ Carrier \_\_\_\_\_ Cost  
\_\_\_\_\_

HR inhouse/outsourced \_\_\_\_\_ HRIS \_\_\_\_\_ (tech system) Est cost \_\_\_\_\_ I-9 verifications  
\_\_\_\_\_

Screening Y/N whom? Drug Testing Y/N –what type \_\_\_\_\_

PEO existing relationship Y/N co-employer name \_\_\_\_\_ Admin Fees \_\_\_\_\_ WC cost \_\_\_\_\_ (detail  
expenses) SUTA rate(s) \_\_\_\_\_ Group/Retirement Plans via PEO or carved out

Workers Comp -Type of Plan: Guaranteed Cost, Dividend, Retro, Large Deductible



**Required ATTACHMENTS:**

Workers Comp: ACORD app, currently valued losses for last 3-5 years, exp mod work sheet & safety plans

Employee Benefits: Group Census, Health Questionnaire, copy of group & retirement plans