ALLSTAFF
PAYROLL

EMPLOYEE INSURANCE BENEFITS

***OPTIONAL FORM** – Only fill this out if interested in insurance benefits

Employee Name: _____

Employer Name: _____

Phone (_____) _____ - _____ E-mail address: _____

Is this for: ☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Family

Your Age: _____ Spouse Age: _____ Number of Children: _____

Do you use tobacco products? ☐ Yes ☐ No Spouse? ☐ Yes ☐ No

Please check all benefits that you may be interested in:

☐Health

☐Dental

☐Vision

☐Life Insurance

☐Cancer Insurance

☐On/Off the Job Accident Insurance

☐Hospitalization

☐Intensive Care

☐Other: _____