# Employee Benefits Survey

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| Date: |  | Position Held: |  | Date Hired: |  |

Which of the following benefits does your employer currently provide? Check all that apply.

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| --- | --- | --- | --- |
| Health Insurance |  | Dental Insurance |  |
| Vision Insurance |  | Life Insurance |  |
| Disability insurance |  | Retirement plan |  |
| Health savings account |  | Vacation |  |
| Sick time accrual |  | Personal time accrual |  |

## If your employer provides you with health, dental or vision coverage, please answer the questions below.

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| Name of carrier: |  | | | Do you have single or family coverage? | |  |
| What is your premium? | |  | | | [weekly/monthly/annually] | |
| What is the deductible amount each year? | | |  | | | |

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| Is there a cap on out-of-pocket expenses? | Yes | | No | If yes, what is this amount, if any? |  |
| What is the lifetime limit on medical coverage? | |  | | | |

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| Is there a co-pay required for office visits? | Yes | No | If yes, what is the co-pay amount? |  |

How satisfied are you with your health, dental and vision coverage?

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Would you recommend this insurance carrier to others? Why or why not?

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## Please answer the following questions concerning vacation and paid time off.

How many vacation days do you receive annually? [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] Sick days? [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Personal days? [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] Other paid time off? [\_\_\_\_\_\_\_\_\_\_\_\_\_]

What holidays are you normally paid for, if any?

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| Are you required to use any of your paid time off for annual events such as plant shutdown? | | Yes | No |
| If yes, how many days are you required to use in this manner? |  | | |

## Please provide us with some information about your company’s retirement plan.

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| What percent if any does your employer contribute to a 401k plan on your behalf? |  |

Are you able to make early withdrawals from this plan? If so, under what circumstances?

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When will you become fully vested in your company’s retirement or 401k plan?

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