Globe Life
Liberty National Division

Benefits Fact Sheet

Business Name: _____

Contact Name: _____
If not business owner, is business owner aware of implementation? ☐ Yes ☐ No

Are you the only decision maker for benefits? ☐ Yes ☐ No
If not, who else needs to be involved? _____

Year Business was Established: _____

How many full time employees? _____
# of Employees employed six months or longer? _____

Health Insurance? ☐ Yes ☐ No
Company:_____

Supplemental benefits? ☐ Yes ☐ No
Company: _____
Products offered: _____
Employee participation: _____

Group Life Insurance? ☐ Yes ☐ No How much? _____
At retirement: ☐ Terminates ☐ Converts ☐ Reduces

In-House Payroll? ☐ Yes ☐ No
Person who enters payroll? _____
Person who will pay monthly invoice? _____

If no, please list the Payroll Company: _____

Payroll Frequency ☐ Weekly ☐ Bi Weekly ☐ Semi Monthly ☐ Monthly

What day do employees get paid? ☐ M ☐ T ☐ W ☐ TH ☐ F
What day is payroll run on? ☐ M ☐ T ☐ W ☐ TH ☐ F
If Bi Weekly, date of last check? _____

Email for Online Billing: _____
Billing Address, If Different From Physical? _____