CALIFORNIA HISPANIC CHAMBER OF COMMERCE

Employer Questionnaire

EMPLOYER INFORMATION *(Please Print)*			
Business Name:			
Street Address:			
City:	State:	Zip Code:	
Brief Description of Business: (ie., Restaurant, Florist, etc.)			
California Hispanic Chamber of Commerce Membership Number: **TO BE PROVIDED BY THE CHCC - PLEASE LEAVE BLANK**			
Estimated Number of Full-time Employees:	Estimated Number of Part-time Employees:		
Contact Person Name:			
Contact Person Phone:	Contact Person Email:		

EMPLOYER CONTRIBUTION

☐ **Employer will not contribute towards any program**

☐ **Employer will contribute _____%**

(A Representative will contact you to determine the exact amount and programs)

SIGNATURE			
Print Name:	Title:	Signature:	Date:

This is NOT an application for health care coverage.

This form is subject to approval by Apogee Members LLC. d/b/a Apogee Health Insurance Solutions. Do not cancel existing coverage until approved in writing.

This form does not bind the signer to any financial liability for any products enrolled in by themselves or their employees unless informed of and agreed to in a separate application for coverage.

Please return form to:

Fax: 866-402-4243
Email: info@apogeehealth.solutions
Mail: CHCC Health
PO Box 585
Rosemont, IL 60018