

Upon completion of this form fax it to 702-804-5840.

**This form must be submitted to eOutsource Group to receive commissions for any referral.**

**Consultant Information:**

Today's Date: \_\_\_\_\_

Consultant Name: \_\_\_\_\_ Phone #: (     ) \_\_\_\_\_

**Prospect Information:**

Company: \_\_\_\_\_ Type of business: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Position: (   ) Owner (   ) Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Owners Name: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Fax: (     ) \_\_\_\_\_

Email: \_\_\_\_\_

No ee's: \_\_\_\_\_

How heard about us: \_\_\_\_\_

Interest: Check all the boxes they have shown interest in.

- HR/Payroll       Health       Dental       Vision       Workers Comp  
 Retirement Plan     Other \_\_\_\_\_

**General Information:**

(Please provide any information you believe would be important for us to know prior to calling this account. ie: why they are looking, what are their hot buttons, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

eOutsource Group Company to complete this section:

Rcvd Lead: \_\_\_\_\_ Lead to: \_\_\_\_\_ Date: \_\_\_\_\_

Status: (   ) Inq only (   ) In Process (   ) Info submitted to prospect \_\_\_\_\_ (   ) Sold Date: \_\_\_\_\_