Employee Census Form

Date Requested: _____ **Effective Date:** _____ **REP:** _____

Please fill in all areas as completely as possible.

Business Name:				**Association Name/Direct Coverage:**				
Contact Name:						**County:**		
Business Address:			**City:**		**State:**		**Zip Code:**	
Business Phone:		**Ext.**		**Business Fax:**			**SIC/NAICS Code:**	
Length of Time in Business:			**Description or Type of Business:**					
Existing Insurance Carrier:					**Number of Hours Worked for Full Time:**			
Number of Eligible Employees:			**Number of Insured's:**			**Number of Waivers:**		
Employer Contribution (%):		**Employee:**		**Dependent(s):**		**Dependent Eligibility Age:**		

Please fill in information requested below as completely as possible to obtain accurate quote(s).

*Medical Contract Type Code: E=Employee, HW=Husband & Wife, E/Child=Employee & Child, E/Children-Employee & Children F=Family, 6=Emp 65, 7=HW both 65, P=Fam Emp 65, S=Fam Spouse 65

Full Name	DOB	Gender (M/F)	Medical Contract Type (see above)*	# of Children Enrolling	Status F=Full Time P=Part Time R=Retired C=Cobra M=Medicare Primary 1099=1099	Employee Waiver Yes or No	Reason for Waiver (Spousal coverage, Not Eligible, Etc.)	Dental	Vision	Zip Code of Residence	Smoker Yes/No	Occupation	Annual Salary