



Group Census Form for Health, Life and Disability Insurance

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1-25 Group Census

Company Name:										Tax ID #:	
Company Main Address:										County:	
Contact Person:					Phone:			Fax:			
NAICS CODE:							SIC CODE:				
Requested Eff Date:			Total Employees:		FT EEs:		PT EEs:		COBRA EEs:		
Current Coverage:											

*** Must enter the Date of Birth (DOB) for all Dependents wishing to be covered. Enter M or F before the DOB for Gender. Enter a T after the DOB if the Dependent uses tobacco.**

Who Needs Coverage?																	
Employee Name	Employee DOB	Employee Gender	Employee Tobacco Use?	Coverage Type (Key Below)	Employee Home Zip	Spouse DOB	Spouse Gender	Spouse Tobacco Use?	* Dep 1: Gender & DOB	* Dep 2: Gender & DOB	* Dep 3: Gender & DOB	* Dep 4: Gender & DOB	* Dep 5: Gender & DOB	Employee Occupation (Include for Life & Disability Quotes)	Employee Salary (Include for Life & Disability Quotes)	Household Size (Include For Tax Subsidy Estimate Only)	Household Income (Include For Tax Subsidy Estimate Only)
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25																	

Coverage Type Key	
Employee	EE
Employee + Spouse	ES
Employee + Child(ren)	EC
Family	F
Cobra	C
Other Coverage	OC
No Coverage	NC
Not Eligible	NE