

EMPLOYEE CENSUS

Name of Company: _____
 Street, City, State _____
 County: _____
 SIC Code: _____ Industry Type: _____ Workers Comp Carrier: _____
 Contact Name: _____ Phone #: _____ Fax #: _____ email: _____

% or \$ that Employer contributes towards premium? _____ Probationary Period for New Hires: _____
 Do you currently have anyone on COBRA? Yes No for Re-Hires: _____
 (If Yes, please include on census)

PLEASE LIST ALL ELGIBLE EMPLOYEES WHETHER CURRENTLY ON PLAN OR NOT Date Business Established: _____
 * TYPE Codes- Please put whether it is a Single (S), Parent/Child (PC), Husband/Wife (H/W), or Family (F) Plan Tax ID# _____

Full-time Status Note: Most carriers require 30 hours/week to be considered full-time eligilbe (Part-Time, Seasonal or Temporary employees are generally not eligible)

IF AN EMPLOYEE IS NOT COVERED UNDER YOUR PLAN, PLEASE WRITE IN THE REASON WHY NEXT TO THEIR NAME.
 (I.E. ON SPOUSES PLAN, COVERED ELSEWHERE, DOES NOT WANT, ETC..)

	Employee Name	Male /Female	Date of Birth	Date of Birth Spouse (if covered)	TYPE of coverage				Reason not covered	# of Covered Children	Zip Code	Additional notes (if Dual Choice please note plan type, if COBRA please note)	EE's email
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Current Carrier & Renewal Month: _____ Please Include a copy of your most recent Medical Invoice with this completed form.