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? _____ **for Re-Hires:** _____

(If Yes, please include on census) **# Hours per week to be eligible** _____

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 1st Name	Last Name	Male /Female	Date of Birth	Date of Birth Spouse (if covered)	TYPE of coverage Sin	P/C	H/W	Fam	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.**