Name of Company:

Please return to Davevic Benefits via fax #724-458-7261
or email to service@davevic.com
or send secure via ShareFile link:
https://davevic.sharefile.com/r-r0bed9afbea046689

Date:

Address:
City, State Zip:
County:
Tax ID:
SIC Code: **Industry Type:** **Phone Number:**
Workers Comp Carrier:
Contact Name: **email:** **Fax Number:**
% or $ that the Employer contributes towards premium:
Probationary Period for New Hires: **Probationary Period of Re-hires:**
Date Business Established: **# Hours per week to be eligible:** 40

Anyone on COBRA? *Please include them on this census if they will still be eligible on effective date*

Please list ALL ELIGIBLE employees whether currently covered or not.

If an employee is NOT currently enrolled under your plan, please write under "Status" the reason they are not covered. (i.e. Spousal Coverage, Parent Coverage, VA Coverage, Waiver)

*Employee Number	*Employee or Dependent	*Last Name	*First Name	*Date of Birth (MM/DD/YYYY)	*Gender M or F	Zip Code	*Status Active or COBRA	*Tobacco Within the past 6 months, have you used tobacco regularly (4 or more times/week on average excluding religious or ceremonial uses)? Y or N	Tobacco If yes, when was the last time you used tobacco regularly? (MM/YYYY)	*Dependent Type Spouse/Partner or Child/Dependent (Required for Dependents only)	Coverage Tier (S=Single, PC=Par-Child(ren), HW=Husb-Wife, F=Family, W=Waive)
	Employee										