HEALTH, DENTAL & VISION CENSUS FORM

Name of Company:	**Contact Person:**
Address:	**County:**
Phone Number:	**Type of Business:**
Fax Number:	**E-Mail Address:**

1	2	3	4	5	6
Employee Name or Employee #	Male or Female	Age or Date of Birth	Spouse's Age or Date of Birth	Type of Coverage 1-Single 2-Emp/Child 3-Emp/Children 4-Emp/Spouse 5-Full Family	Ages of Children
1					
2					
3					
4					
5					
6					
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8					
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12					
13					
14					
15					

Proposed Effective Date ______________________________

Which of the above are COBRA? ______________________________

Which of the above are Retirees? ______________________________

Are there any major health problems for covered members such as heart, cancers, diabetes, etc?

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Current Carrier:	Current Rates
Type of Benefits:	Single:
	Emp/Child:
	Emp/Children:
	Emp/Spouse:
	Full Family:

1	2	3	4	5	6
Employee Name or Employee #	Male or Female	Age or Date of Birth	Spouse's Age or Date of Birth	Type of Coverage 1-Single 2-Emp/Child 3-Emp/Children 4-Emp/Spouse 5-Full Family	Ages of Children
16					
17					
18					
19					
20					
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1	2	3	4	5	6
Employee Name or Employee #	Male or Female	Age or Date of Birth	Spouse's Age or Date of Birth	Type of Coverage 1-Single 2-Emp/Child 3-Emp/Children 4-Emp/Spouse 5-Full Family	Ages of Children
53					
54					
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