

# HEALTH, DENTAL & VISION CENSUS FORM

<b>Name of Company:</b>	<b>Contact Person:</b>
<b>Address:</b>	<b>County:</b>
<b>Phone Number:</b>	<b>Type of Business:</b>
<b>Fax Number:</b>	<b>E-Mail Address:</b>

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					
7					
8					
9					
10					
11					
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?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

1 Employee Name or Employee #	2 Male or Female	3 Age or Date of Birth	4 Spouse's Age or Date of Birth	5 Type of Coverage  1-Single 2-Emp/Child 3-Emp/Children 4-Emp/Spouse 5-Full Family	6 Ages of Children
16					
17					
18					
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52					

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