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** Type M or F	**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?

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** Type M or F	**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					
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1	2	3	4	5	6
Employee Name or Employee #	**Male or Female** Type M or F	**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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