

## 1 to 50 Group Rate Census

Company Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

City/Zip code: \_\_\_\_\_

Industry: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Current Plan: \_\_\_\_\_

Circle if desired: Maternity Life Dental Disability Workers comp.

What types of plans would you like to see? HMO  PPO  POS  Deductible? \_\_\_\_\_

Are there any employees with ongoing medical concerns? \_\_\_\_\_

Other comments: \_\_\_\_\_

	Employee	Sex	Age/ DOB	Spouse Y/N	No. of Children	County
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						