

Group Employee Census*

Group Name _____

Contact Person _____

Address _____

Telephone Number _____ Fax Number _____

E-mail: _____

Name (optional)	Sex	Date of Birth / Age	Spouse DOB/Age (only if covered)	# Children to be covered	Medical Cov. Code**	Dental Cov. Code**	Life Ins. Amount	Annual Salary ***	Occupation	Date of Hire
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

*Please include all Full-time owners and employees of the firm. If they have other insurance, and will not be participating in this plan, please use the Coverage Code 'N'.

**Coverage Codes: EE - Employee Only
 ES - Employee & Spouse
 EC - Employee & Children
 EF - Employee & Family
 N - None

***Annual Salary only needed if applying for Disability Income

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