THE INSURANCE STORE, INC.

GROUP HEALTH CENSUS
Effective Date:

Business Name:		NUMBER OF EMPLOYEES
Address:		NUMBER OF EMPLOYEES WORKING 17.5+ HRS
City, State, Zip:		NUMBER OF ELIGIBLE EMPLOYEES
Phone: / Fax:		NUMBER OF EMPLOYEES ENROLLING
Is this location your Headquarters?: Yes		EMPLOYER CONTRIBUTION PER EMPLOYEE
Employer Tax ID:		EMPLOYER CONTRIBUTION PER DEPENDENT
Industry: (SIC)		EMPLOYEE ELIGIBILITY HOURS PER WEEK
Contact Person:		EMPLOYEES ON CONTINUATION OR COBRA
E-mail address:		DAYS PROBATIONARY PERIOD
CURRENT MEDICAL CARRIER:		
CURRENT DENTAL CARRIER:		EMPLOYEE ELIGIBILITY HOURS PER WK FOR DENTAL
WORKERS COMP CARRIER:		

					Insurance Enrollment Status							
	LIST ALL EMPLOYEES REGARDLESS OF HOURS WORKED	SEX M/F	DOB	DOH	EE	ES	F	EC	N	W	If enrolling dependents list ages	ZIP CODE
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
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15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
	Total Enrolling				**0**	**0**	**0**	**0**	**0**	**0**		

KEY:			
DOB = Date of Birth	**M** = Medical Only	**D =** Dental Only	**M/D =** Medical & Dental
EE = Employee Only	**ES =** Employee+Spouse	**F =** Employee+Family	**EC =** Employee+child(ren)
W = Waiving	**N =** Not Eligible	**P =** Probationary Period & Eligibility Date	
HOGC = Has other Group Coverage	**DOH =** Date of Hire	**P/T** = Part Time	

X ____
signature title

Questions please contact:
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12/17/2012