



3237 Ranch Park Trail, Round Rock, TX 78681
 D: (512) 341-3222 F: (512) 532-6771

Instructions for completing the Group Health Census form

- 1) Print and complete the form below.
- 2) Print and complete the form on the next page. If over 20 employees please print additional copies of form.
- 3) Fax completed form to (512) 532-6771 and allow 3-5 business days to receive quotes back.
- 4) Please call your agent at anytime for help in completing the form or to answer any questions.

Company Contact Information

Company Name: _____
Company Address: _____

Contact Name: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Current Coverage Information

Current Carrier: _____
Current Plan: _____
Current Risk Rate (if known): _____
How Long with Current Provider?: _____
Reason For Changing?: _____
Renewal Date? _____
Current Monthly Premium: _____

Group Health Preferences

(Circle Preferences)

Carriers:	Aetna	Blue Cross Blue Shield	Humana	Unicare	United Healthcare		
Plan Type:	PPO	HMO	H.S.A.				
Deductible:	\$250	\$500	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000
Coinsurance %:	100/0	90/10	80/20				
Max Out-of-pocket:	\$1,000	\$2,000	\$3,000	\$4,000	\$5,000	\$8,000	
Other Benefits:	Maternity	RX	Dental	Vision	Life	STD	LTD



GROUP HEALTH INSURANCE CENSUS FORM

Company Name: _____
 SIC Code: _____ Nature of Business _____

EO = Employee Only **ES** = Employee & Spouse **EC** = Employee & Child(ren) **EF** = Employee & Family

#	Employee Name	Birthdate (6 digits)	Gender (M/F)	Home Zip Code	Enrollment Code (See above codes)	Spouse Birthdate	# of Dependents To be covered	Please List Any Existing Medical Conditions
	<i>Suzy Sample</i>	<i>040374</i>	<i>F</i>	<i>78681</i>	<i>EF</i>	<i>091875</i>	<i>2</i>	<i>Diabetes II, Migraines</i>
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Please send completed form via fax to (512) 532-6771