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GROUP HEALTH & DISABILITY INSURANCE CENSUS

Date: _____

Company Name: _____

Your Company Specializes in? _____

Street Address: _____

City, State, Zip: _____

County: _____

In order to get an accurate comparison, please provide the following information:

Annual Deductible to be considered _____ (e.g. \$500-\$1,000 or higher)

Acceptable Coinsurance %: _____ (example 80%/20% plan)

Do you want an Office Visit Copay? _____ (example \$20 - \$30 per visit)

Do you want a Prescription Drug card? _____

Must we quote Dental coverage? _____

Must we quote Life Cover? _____ Amount of Life Cover needed? _____

Name of Employee	Male / Female	E.E. Date of Birth	Employee Age	Spouse's Date of Birth (If applicable) **	No. of children (ages not important)	Residence Zip Code

**** NOTES:**

If no spouse, please note **Single** or **Divorced** - only if there are dependents

E.E. = Employee

If spouse has his/her own insurance, leave spouse details out.