

95 N. Research Dr. Suite 100 Edwardsville, IL 62025

Tel: 800.556.2663 Fax: 618.692.9865 2236 Mason Ln Ballwin, Mo 63021

Tel: 888.868.6560 Fax: 314.821.5779

GROUP HEALTH & DISABILITY INSURANCE CENSUS

Date:							
Company Name:							
Your Company Specializes in?							
Street Address:							
City, State, Zip:							
County:							
In order to get an accurate compari	son, please	provide the fol	lowing informat	ion:			
Current Health Insurance Carrier:	-	-	_				
Current Annual Deductible		(e.g. \$1	,000 - this is ver	y important)			
Current Physician office Copay:							
Current Coinsurance %:							
Current Monthly Premium:				-			
Dental cover needed?			needed?				
When do you renew your Health In:							
		T	1	T	T		
Name of Employee	Male /	E.E. Date of	Employee Age	Spouse's Date	No. of	Residence	
	Female	Birth		of Birth (If	children	Zip Code	
				applicable) **	(ages not		
					important)		
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** 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.