



EMPLOYEE CENSUS

Company Name: _____ FEIN#: _____

Address: _____ Total EE's _____

Contact Person: _____ Phone: _____

E-Mail: _____ Fax: _____

	EMPLOYEE NAME	SEX	DOB/AGE*	STATUS**	COUNTY
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

* Date of Birth or Age as expected effective date.

** Coverage Status Codes:

EE = Employee Only

FF = Full Family

C = Currently under COBRA

ES = Employee & Spouse

WN= Waive coverage (Have other coverage)

EC = Employee & Children

W = Waive coverage (Have no coverage)

Please make the appropriate selections below.

We prefer a ___ HMO plan, a ___ PPO (POS) plan, or a ___ Dual Option (option of HMO/PPO).