

Group Health Insurance Census

This information will be used to obtain quotes for group health insurance coverage. To get an accurate quote please furnish all requested information and list any known medical conditions or medications taken by anyone to be included on the insurance plan.



Company Name _____

Address _____

City, State, Zip _____

Phone Number () _____

Phone Number (866) 724 7123

Fax Number (630) 924-7833

www.smallbusinessinsuranceservices.com

Nature of business _____

Requested Effective Date _____ S.I.C. _____ Contact Person: _____

Total # of Full-time Employees _____

of Employees to be on plan _____

of out-of-state employees to be covered _____

Current Insurance Company _____

Current Deductible _____

Employee Name	Sex	Date of Birth	Spouse DOB (If to be covered)	# of children (if to be covered)	Coverage* (see box below)	Home Zip Code
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25						

Use separate sheet if needed

Coverage* Needed	Medical Conditions (indicate employee #)
E = Employee Only	
ES = Employee & Spouse Only	
EC = Employee & Child(ren) Only	
FF = Full Family Coverage	