Census Information – Group Health

Business Name _____ Current Carrier_____
Address _____ City _____ ST _____ Zip _____
County _____Exact Nature of Business or SIC Code _____
Current Benefits: (deductibles, co-insurance limits, co-pays, drug card) _____
_____
Please quote these additional benefits: ___ life ___ disability ___dental ___drug card upgrade ___ accident insurance

Agent Name _____ Phone _____ Email _____

MEDICAL QUESTIONS

Yes No Do you have any employees or dependents who are pregnant?
Yes No Has anyone been confined to a hospital in the past 24 months?
Yes No Are any of your employees currently disabled?
Yes No Has anyone incurred $2,500 or more in medical expenses in the last 12 months?
Yes No Are any of your employees on COBRA or State Continuation?
Yes No Has anyone received treatment for cancer, stroke, heart disorder, immune system disorder, diabetes, gastric bypass, or alcohol or drug dependency disorder?

If yes, please provide the following information. If additional room is needed, please attach another sheet.

Employee/Dependent Name: _____
Diagnosis _____
Date of Diagnosis _____
Date(s) of Treatment _____
Medications _____
Is the condition ongoing? _____

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Diagnosis _____
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Date(s) of Treatment _____
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Is the condition ongoing? _____

EMPLOYEE NAME	SEX	DATE OF BIRTH OR AGE	SPOUSE DOB OR AGE (IF COVERED)	NUMBER OF CHILDREN