

**Group Health Census**

Business Name	_____	Business Phone	_____
Contact Name	_____	Fax Number	_____
Business Address	_____		
City	_____	State	_____
		Zip Code	_____
		County	_____
Nature of Business	_____	E-Mail Address	_____
Current Carrier	_____	Current Monthly Premium	_____
Plan Highlights:	_____		
Deductible	_____	Coinsurance	_____
RX Card	_____	OV Co-Pay	_____
		ER Co-Pay	_____
OOP Maximum	_____	Life Insurance Amount	_____
Dental Annual Maximum	_____	Deductible	_____
		Coinsurance	_____
Known Medical Conditions:	_____		
	_____		
	_____		
Short-Term Disability	Elimination Period: _____	Weekly Max	_____
Long-Term Disability	Elimination Period: _____	Weekly Max	_____