THE INSURANCE STORE, INC.

GROUP HEALTH CENSUS

Effective Date: _____

Business Name:	_____ NUMBER OF EMPLOYEES
Address:	_____ NUMBER OF EMPLOYEES WORKING 17.5+ HRS
City, State, Zip:	_____ NUMBER OF ELIGIBLE EMPLOYEES
Phone: / Fax:	_____ NUMBER OF EMPLOYEES ENROLLING
Is this location your Headquarters?: Yes	_____ EMPLOYER CONTRIBUTION PER EMPLOYEE
Employer Tax ID:	_____ EMPLOYER CONTRIBUTION PER DEPENDENT
Industry: (SIC)	_____ EMPLOYEE ELIGIBILITY HOURS PER WEEK
Contact Person:	_____ EMPLOYEES ON CONTINUATION OR COBRA
E-mail address:	_____ DAYS PROBATIONARY PERIOD
CURRENT MEDICAL CARRIER:	
CURRENT DENTAL CARRIER:	_____ EMPLOYEE ELIGIBILITY HOURS PER WK FOR DENTAL
WORKERS COMP CARRIER:	

				Insurance Enrollment Status								
	LIST ALL EMPLOYEES REGARDLESS OF HOURS WORKED	**SEX M/F**	**DOB**	**DOH**	**EE**	**ES**	**F**	**EC**	**N**	**W**	**If enrolling dependents list ages**	**ZIP CODE**
1												
2												
3												
4												
5												
6												
7												
8												
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10												
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17												
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21												
22												
23												
24												
25												
	Total Enrolling				**0**	**0**	**0**	**0**	**0**	**0**		

KEY:			
DOB = Date of Birth	**M** = Medical Only	**D =** Dental Only	**M/D =** Medical & Dental
EE = Employee Only	**ES =** Employee+Spouse	**F =** Employee+Family	**EC =** Employee+child(ren)
W = Waiving	**N =** Not Eligible	**P =** Probationary Period & Eligibility Date	
HOGC = Has other Group Coverage	**DOH =** Date of Hire	**P/T** = Part Time	

X _____

signature title

Questions please contact:

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11/12/2021