# Employee Census

**EMPLOYER INFORMATION:**

In the space provided below please provide the name and address of your company, the name, phone number and email of the contact, a brief description of your business, your SIC (if known) and the date that you wish your benefits to begin. In addition please indicate the benefits for which you would like us to obtain quotes.

| | | | | |
|---|---|---|---|---|
| **Employer Name:** | | **Address:** | **City/State:** | **Zip:** |
| **Contact Name:** | | **Contact Phone:** | **Contact Email:** | |
| **Business Description:** | | **Are all employees, including executives, covered by Workers' Compensation?** ☐Yes ☐ | | |
| **SIC (If Known):** | | **Desired Effective Date:** | | |
| **Requested Benefits:** | ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ Short-Term Disability ☐ Long-Term Disability ☐ Long-Term Care ☐ 401(k) ☐ Flexible Spending Account ☐ Premium Only Plan | | | |

**EMPLOYEE INFORMATION:** **# of Full-Time Employees: _____ # of Part-Time Employees: _____**
**# of Employees Waiving Coverage:_____**

| Name | Date of Birth | Gender (M/F) | Relationship to Employee (Employee; Spouse; Child) | Residential ZIP Code | E = Enroll W = Waive | Title (For Disability and/or Life Coverage Only) | Annual Salary (For Disability and for Life Coverage if Life Coverage is Based on Salary) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| Name | Date of Birth | Gender (M/F) | Relationship to Employee (Spouse; Child) | ZIP Code | E = Enroll W = Waive | Title (For Disability and/or Life Coverage Only) | Annual Salary (For Disability and/or Life Coverage Only) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |