



Small Group Census Form – Illinois

Mail or fax census to: UNICARE • P. O. Box 5007 • Bolingbrook, IL 60440-5007 • Fax (800) 531-1415

Group Name _____ Date _____

SIC Code/Industry (Provide detailed description) _____ Agent Name _____

_____ Agent Tax ID No./SSN _____

Group Contact _____ Address _____

Address _____ City _____

City _____ State _____ ZIP _____

State _____ ZIP _____ Phone Number _____

Phone Number _____ Fax Number _____

Fax Number _____ E-mail _____

Proposal to be Faxed Mailed Rates Only Benefits Only Rates and Benefits

Date proposal needed _____ Requested effective date _____

MEDICAL COVERAGE SELECTION				PREMIUM RANGE
High Option	Medium Options	Low Options		
<input type="checkbox"/> UNICARE Premier No Deductible	<input type="checkbox"/> UNICARE 750 <input type="checkbox"/> UNICARE 500	<input type="checkbox"/> UNICARE 2000 <input type="checkbox"/> UNICARE 1000	<input type="checkbox"/> UNICARE Saver 1000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

EMPLOYER CONTRIBUTION	Medical	Dental
	<input type="checkbox"/> Defined Contribution 100 <input type="checkbox"/> Defined Contribution 80 <input type="checkbox"/> Defined Contribution Select \$ _____ <input type="checkbox"/> Traditional Contribution _____%	<input type="checkbox"/> Defined Contribution 15 <input type="checkbox"/> Defined Contribution Select \$ _____ <input type="checkbox"/> Traditional Contribution _____%

GROUP TERM LIFE	DENTAL COVERAGE SELECTION
<input type="checkbox"/> A – Flat Amount \$15,000 <input type="checkbox"/> B – Flat Amount \$15,000 to \$250,000 (increments of \$5,000) <input type="checkbox"/> C – Graded Benefits \$30,000 \$15,000	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate choice High Options Medium Options <input type="checkbox"/> High Option FFS <input type="checkbox"/> Standard FFS <input type="checkbox"/> High Option PPO <input type="checkbox"/> Standard PPO Low Options <input type="checkbox"/> Basic FFS <input type="checkbox"/> Basic PPO
<input type="checkbox"/> D – Graded Benefits \$50,000 \$25,000 <input type="checkbox"/> E – Graded Benefits \$100,000 \$50,000 <input type="checkbox"/> Dependent Life Option	

Medical Coverage Codes for Coverage Information
 EE - Employee ES - Employee/Spouse EC - Employee/Child EC+ - Employee/Children EF - Employee/Family

	Employee Name	Sex	Date of Birth or Age	Employee Zip Code	Coverage Information	COBRA
1					EE ES EC EC+ EF	
2					EE ES EC EC+ EF	
3					EE ES EC EC+ EF	
4					EE ES EC EC+ EF	
5					EE ES EC EC+ EF	
6					EE ES EC EC+ EF	
7					EE ES EC EC+ EF	
8					EE ES EC EC+ EF	
9					EE ES EC EC+ EF	

	Employee Name	Sex	Date of Birth or Age	Employee Zip Code	Coverage Information					COBRA
10					EE	ES	EC	EC+	EF	
11					EE	ES	EC	EC+	EF	
12					EE	ES	EC	EC+	EF	
13					EE	ES	EC	EC+	EF	
14					EE	ES	EC	EC+	EF	
15					EE	ES	EC	EC+	EF	
16					EE	ES	EC	EC+	EF	
17					EE	ES	EC	EC+	EF	
18					EE	ES	EC	EC+	EF	
19					EE	ES	EC	EC+	EF	
20					EE	ES	EC	EC+	EF	
21					EE	ES	EC	EC+	EF	
22					EE	ES	EC	EC+	EF	
23					EE	ES	EC	EC+	EF	
24					EE	ES	EC	EC+	EF	
25					EE	ES	EC	EC+	EF	
26					EE	ES	EC	EC+	EF	
27					EE	ES	EC	EC+	EF	
28					EE	ES	EC	EC+	EF	
29					EE	ES	EC	EC+	EF	
30					EE	ES	EC	EC+	EF	
31					EE	ES	EC	EC+	EF	
32					EE	ES	EC	EC+	EF	
33					EE	ES	EC	EC+	EF	
34					EE	ES	EC	EC+	EF	
35					EE	ES	EC	EC+	EF	
36					EE	ES	EC	EC+	EF	
37					EE	ES	EC	EC+	EF	
38					EE	ES	EC	EC+	EF	
39					EE	ES	EC	EC+	EF	
40					EE	ES	EC	EC+	EF	
41					EE	ES	EC	EC+	EF	
42					EE	ES	EC	EC+	EF	
43					EE	ES	EC	EC+	EF	
44					EE	ES	EC	EC+	EF	
45					EE	ES	EC	EC+	EF	
46					EE	ES	EC	EC+	EF	
47					EE	ES	EC	EC+	EF	
48					EE	ES	EC	EC+	EF	
49					EE	ES	EC	EC+	EF	
50					EE	ES	EC	EC+	EF	