

BUSINESS CENSUS



Group Name: _____ Group Number: _____

IMPORTANT NOTE: This form must be accompanied by your State Quarterly Wage & Tax Report (or applicable tax documentation based on type of business arrangement noted below).

Please check the type of business arrangement:

- Sole Proprietorship
 Partnership
 Corporation
 S-Corporation
 LLC
 Other

Please provide the most recent tax forms that correspond to the box checked, including any payroll or substantiating tax forms.

EMPLOYEE CENSUS

Please list all employees in your firm including owners, partners, and managers, whether enrolled for coverage or not. (Attach a second page if necessary.)

	NAME	HIRE DATE	HOURS WORKED PER WEEK	STATUS*	TITLE	WAIVING YES/NO (Y/N)	IF WAIVING, LIST REASON: E.g. Spouse's Employer Plan, COBRA, Medicare/Medicaid, Individual Plan, Military, Other (Explain) Include carrier name, ID #, effective date
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

* STATUS (key)*

- | | | |
|-----------------------------------|---|-----------------------------------|
| F – Full-time | R – Retired | A – Active Partner |
| P – Part-time | C – Continuation (State/Federal) | PP – Passive Partner |
| T – Temporary or Seasonal | D – Totally Disabled Employee | WP – Within Waiting Period |
| I – Independent Contractor | PO – Probationary Period | O – Other |

The employer contributes _____% (enter%) toward full-time eligible employee medical premium, if that employee chooses to participate in this group coverage.

The employer agrees that all the information shown above is correct and complete.

Authorized Signature & Title _____ Date _____

Business Telephone No. _____

*This form is being used as part of our internal administrative process to verify eligibility and participation requirements. **Therefore, it is imperative that the information submitted is complete.** It will not be used to verify health status of any individual employee.*