



# Small Group Census Form – Indiana

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
<b>High Option</b>	<b>Medium Options</b>	<b>Low Options</b>		
<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 <b>High Options</b> <b>Medium Options</b> <input type="checkbox"/> High Option FFS <input type="checkbox"/> Standard FFS <input type="checkbox"/> High Option PPO <input type="checkbox"/> Standard PPO <b>Low Options</b> <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	
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50					EE ES EC EC+ EF	