



# Small Group Census Form - Virginia

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

Date \_\_\_\_\_

Group Name \_\_\_\_\_

Agent Name \_\_\_\_\_

Group Contact \_\_\_\_\_

Agent Tax ID No./SSN \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Fax Number \_\_\_\_\_

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

E-mail \_\_\_\_\_

Date proposal needed \_\_\_\_\_ Requested effective date \_\_\_\_\_

<b>MEDICAL COVERAGE SELECTION</b> <input type="checkbox"/> ALL PLANS High Option <input type="checkbox"/> UNICARE Premier No Deductible Medium Options <input type="checkbox"/> UNICARE 750 <input type="checkbox"/> UNICARE 500 Low Options <input type="checkbox"/> UNICARE 1000 <input type="checkbox"/> UNICARE Saver 1000			<b>RISK ADJUSTMENT FACTOR</b> <input type="checkbox"/> .80 <input type="checkbox"/> 1.10 <input type="checkbox"/> 3.00 <input type="checkbox"/> .90 <input type="checkbox"/> 1.20 <input type="checkbox"/> 1.00 <input type="checkbox"/> 1.30		
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<b>EMPLOYER CONTRIBUTION</b>	Medical <input type="checkbox"/> Defined Contribution 100 <input type="checkbox"/> Defined Contribution 80 <input type="checkbox"/> Defined Contribution Select \$ _____ <input type="checkbox"/> Traditional Contribution _____ %	Dental <input type="checkbox"/> Defined Contribution 15 <input type="checkbox"/> Defined Contribution Select \$ _____ <input type="checkbox"/> Traditional Contribution _____ %
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<b>GROUP TERM LIFE</b> <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"/> D – Graded Benefits \$50,000 \$25,000 <input type="checkbox"/> E – Graded Benefits \$100,000 \$50,000 <input type="checkbox"/> Dependent Life Option			<b>DENTAL COVERAGE SELECTION</b> High Option <input type="checkbox"/> High Option Plan Medium Option <input type="checkbox"/> Standard Plan Low Option <input type="checkbox"/> Basic Plan		
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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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