

**\*\*PLEASE COMPLETE GROUP CENSUS FORM AND FAX TO: 866-531-4675\*\***

Company Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Tel#: \_\_\_\_\_

Fax#: \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

Current Carrier: \_\_\_\_\_

Type of Business: \_\_\_\_\_

# of Cobra's: \_\_\_\_\_

Industry SIC Code: \_\_\_\_\_

Group Term Life Insurance (Amount): \_\_\_\_\_

Would you like Dental Insurance?: \_\_\_\_\_

Known Medical Conditions: (please describe) \_\_\_\_\_

Number of Employees: \_\_\_\_\_

	Name	M/F	Age/DOB	Zip	COBRA'S
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____