Company Health Census

Group Name:
Name of Group Contact:
Business Address:

City: **State:** **County:**
Other Locations (Yes/No):
Phone:
(Please attach listing of multiple locations)

Current Carrier: **# of Full-time Employees:**

Years in Business: **Employer Contribution %:**

Renewal Date: **Network:**

Current Consultant or Broker:

			Please place an "x" for type of coverage					
Last Name, First Name	**Gender**	**Age or DoB**	**Employee Only**	**Employee Spouse**	**Employee Children**	**Employee Family**	**Declining Coverage**	**Notes**