



Employee Census Form

Medicare Information Section	
Total # of employees working at least 30hrs per week	_____
Total # seasonal or part time employees	_____
Total # of employees on payroll eligible for coverage	_____
Total # of employees enrolling	_____

Employer Name: _____

Contact Person: _____ Address: _____ City: _____ State: _____ Zip: _____

Type of Business: _____ Phone: _____ Fax: _____ County: _____

Requested Effective Date: _____ Email Address: _____

Current Carrier: _____ Current Deductible: _____ Current Plan Type: HMO PPO Traditional

Eligible Employees = working (check one): 30 hours per week 20 hours per week Other: _____

	Name of ALL FULL TIME eligible employees	Date of Hire	Date of Birth	Gender	# of Children	Coverage Level*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

*COVERAGE LEVEL: E = Employee only ES=Employee/Spouse EC = Employee/Child F = Family W# = Waiving (see codes below)

W1: Subscriber has other coverage W2: Coverage through spouse W3: Voluntary Election - no other coverage