SMALL GROUP MEDICAL CENSUS

Business Name: ______________________________

Contact Name: ______________________________

Phone#: ____________________ **Fax#:** ____________________

Email: ______________________________

Employer Contribution (Dollar amount or percentage):______________________________

Employee Name (list family members after each employee if coverage is requested)	Date of Birth	Gender	Zip	Include Coverage For:*	Full Time, Part Time or COBRA

***Employee Only (E), Employee+Spouse (ES), Family (F), Employee+Child (EC), Employee/Children (ECS)**