Census Form for Small Group Health Plan
2-50 Employees

Group Name_____
Address_____
County_____
Telephone_____
Contact Person_____
Effective Date_____
Current Carrier & Plan_____
_____
Please Quote_____

*Family Status - Single, Parent/Child(ren), Husband/Wife, Family

	Employee Name	Sex	Date of Birth	Family Status	Waiving/Applying	Medicare Suppliment?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						

Census Form for Small Group Health Plan
2-50 Employees

*Family Status - Single, Parent/Child(ren), Husband/Wife, Family

	Employee Name	Sex	Date of Birth	Family Status	Waiving/Applying	Medicare Suppliment?
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						