



GROUP CENSUS FORM

Date:

Once completed, save this form and email to **jeanne@dgshealth.com** or fax to **1-888-587-7263**.

If you have questions, please give us a call at: (860) 886-5126

PRIMARY CONTACT NAME

GROUP NAME

ADDRESS

CITY STATE ZIP CODE PHONE NUMBER

EMAIL FAX

Information about your plans, and services interested in:

PROPOSED EFFECTIVE DATE: BENEFITS RENEWAL DATE:

CURRENT COVERAGE Health Life Dental Vision Disability Other

CURRENT CARRIER (S)

COMPANY STRUCTURE Sole Proprietor Partnership Corporation LLC Other

TYPE OF BUSINESS

MORE THAN ONE LOCATION? YES NO EMPLOYEES LIVING OUT OF STATE YES NO

OF FULL-TIME EMPLOYEES (30+ hrs) # OF COBRA's INDUSTRY SIC CODE

% OF COSTS TO BE PAID BY EMPLOYER EMPLOYEE DEPENDENT (S)

ADD'L INFO:

Please see next page for specific employee information needed. If additional pages are needed, please print blank form and copy.



Enrolling Member	Name	M/F	AGE	DOB	ZIP	COBRA (y/n)

If additional employees spaces are needed, please use next page or copy.

