Group Census

Effective Date: _____ Type of Business: _____
Company Name: _____ SIC #: _____
Contact Name: _____ Fax Number: _____
Phone Number: _____
Business Address: _____
City: _____ State: _____ Zip: _____

Employer Premium Contribution **($ or %)**: Employee:_____ Dependent: _____
Employee Probationary Period: **(DOH) (30 days) (60 days) (90 days) (Other)**
Employee weekly hourly requirements **(minimum of 17.5 hours)** : _____ hours

List all employees who work over 17.5 hrs. per week; including those in their group eligibility waiting period, all who are waiving coverage and those who are ineligible under the group's eligiblity requirements **(use the codes listed below)**. Also include **COBRA/Continuation members** on this list. **Please list the dependent information for those dependents who are enrolling under the coverage only and also tobacco information for the employees that will be enrolling on the plan.**

***Enrollment Codes:**	**EE** Employee Only	****Not Enrolling Codes:**	**NE1** Employee in Waiting period
	ES Employee & Spouse		**NE2** Other Insurance Coverage
	EC Employee & Child(ren)		**NE3** Doesn't work required hours
	EF Employee & Family		**NE4** Seasonal or Temp Employee

Employee Name	Enter E (Employee) S (Spouse) C (Child) F (Family)	Employee Gender F/M	Employee Age or Date of Birth	Dependant Ages	Employee Tobacco Yes/No	Enrollment Code *	If Not Enrolling Code **	Date of Hire	Hours worked per week	Currently on COBRA/ State Cont. (X) if Yes	Employee Zip Code
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