

# ADVANCED BENEFIT PLANS, INC.

## CENSUS FORM

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

COUNTY: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

GROUP CONTACT/PLAN ADMINISTRATOR: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

CURRENT INSURANCE CARRIER: \_\_\_\_\_

NAICS/SIC CODE or NATURE OF BUSINESS: \_\_\_\_\_

REQUESTED EFFECTIVE DATE: \_\_\_\_\_ TOTAL ELIGIBLE EMPLOYEES: \_\_\_\_\_

COVERAGE TYPE: PLEASE USE THE FOLLOWING CODES FOR COVERAGE TYPE

EO – EMPLOYEE ONLY ES – EMPLOYEE & SPOUSE EC – EMPLOYEE & CHILDREN F - FAMILY

Emp.	Birthdate	Sex	Type of Coverage	# of Child.	Emp.	Birthdate	Sex	Type of Coverage	# of Child.
1					26				
2					27				
3					28				
4					29				
5					30				
6					31				
7					32				
8					33				
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25					50				

Please Fax form to: 704-933-6042

Attention: Group Insurance Quote

Advanced Benefit Plans, Inc.