GROUP CENSUS FORM

EMPLOYER'S NAME:			City:	Zip Code:
DATE:			Phone:	Industry:

I certify that all employees on this census worked 30 hours or more per week and all employees are actively-at-work as of the date of this form.	Signature

Please complete the following information for ALL employees. Those employees who are covered by another group plan (i.e.; spouse's plan, etc.) should still be listed, indicating that they have coverage elsewhere. Employees on COBRA coverage should also be listed, indicating their COBRA effective date. If you have any questions, call 815-935-7977.

	Employee (Male or Female)			Employee/Dependent Coverage Choice							
		Home Zip Code	Date of Birth MM/DD/YY	Weekly, Monthly, or Annual Wages for Salary-based Life, LTD, STD Quotes	Employee Only	Employee & Spouse	Employee & Child	Family Coverage	Number of Children to be covered	Job Description for STD & LTD Quotes	Cobra Effective Date MM/DD/YY
1											
2											
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19											
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PLEASE INSERT A "W" IN EMPLOYEE ONLY COLUMN IF EMPLOYEE IS WAIVING HEALTH COVERAGE

Secure Care of America, Inc.
815-935-7977
815-935-7974 Fax
888-935-2220 Toll Free

The information provided on this form will be treated as privileged and confidential and used solely for the purpose of quoting group health insurance products.