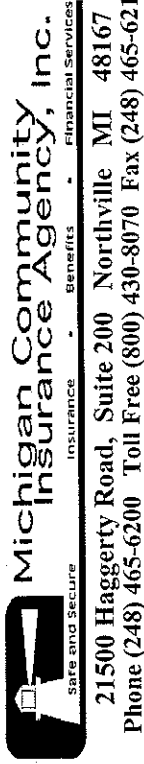


**INSTRUCTIONS: (for quoting purposes)**  
 If you already have a medical, dental vision and/or Short Term Disability plan, please check the boxes for those employees taking that coverage.



New Business

**GROUP MEDICAL, DENTAL, VISION AND SHORT TERM DISABILITY CENSUS**

Employer Name : \_\_\_\_\_ Nature of Business & SIC: \_\_\_\_\_  
 DBA: \_\_\_\_\_ Effective/Renewal Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Agent Name: \_\_\_\_\_  
 City, State & Zip: \_\_\_\_\_ Acct. Mgr (CSR): \_\_\_\_\_  
 County: \_\_\_\_\_ Agency Telephone : 248-465-6200  
 Group Contact Person: \_\_\_\_\_ Agency Fax : 248-465-6215  
 Employer Telephone Number: \_\_\_\_\_ Client Email Address: \_\_\_\_\_

**Status Chart:**  
 EE = Employee Only  
 EC = Employee & Child(ren)  
 ES = Employee & Spouse  
 FF = Employee & Family (3+)  
 FC = Family Continuation (\*\*19-25)

L/O = Life Only  
 M/C = Medicare  
 C = Cobra  
 P/T = Part Time  
 SP = Waived for Spousal Coverage  
 W = Waived all coverage(s)

\*NOTE: Please list each child separately on census that is on Family Continuation.

---Please list "all" employees (including Part-Time, those with Spousal Coverage and Waivers)---

	LAST NAME	FIRST NAME	DOB	M/F	<> Status Chart Code	CHILDREN # OF	MEDICAL Y/N	DENTAL Y/N	VISION Y/N	Short Term Disability Salary/Hrly Wages
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

FOR QUOTING PURPOSES - PLEASE ANSWER ALL THESE QUESTIONS, TO THE BEST OF YOUR ABILITY.

\*\*\*\* Anyone on COBRA? if yes, please list person(s) and date COBRA was effective and will terminate.

\*\*\*\* Are there any pre-existing conditions? If so, please specify.

\*\*\*\* Are any employees or dependents currently pregnant (due date), retired or disabled? If so, please specify.

RETURN FORM TO: Fax (248) 465-6215 or Email: LH@MichiganCommunity.com