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MEDICAL CENSUS

Date: _____ Phone: _____ Fax: _____ Contact: _____
 Address: _____ Zip: _____
 Business Name: _____ Benefits Provider: _____ Years: _____
 Years in Business: _____ Company Contribution: _____ No. of Carriers last 5 years: _____
 Business Type: _____ SIC#: _____ Renewal Date: _____

EE	Employee Only	W*	Waive
EC	Employee & 1 Child	WAC*	Waive - Alternative Carrier from <u>this employer</u>
EC+	Employee & Children	DEC*	Decline
ES	Employee and Spouse	I*	Ineligible
FAM	Full Family		

***Waiver Definitions:**

W: Employees declining coverage due to coverage under another health plan NOT sponsored by this employer.

WAC: Employee declining coverage due to coverage under another health plan sponsored by this employer.

DEC: Employee declining health insurance entirely.

I: Employee not eligible for coverage, including: Temporary or ineligible part-time employees or employees who do not receive the minimum employer coverage.

	Name	Sex	Election Status (See Legend Above)	Date of Birth	Residence Zip Code
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