**Group Census**

Company Name

Address

( ) ( )

Phone Fax

To be used for: ❑ Life ❑ Health ❑ Disability ❑ Long-Term care

If interested in **Health Insurance**, please answer the following:

____ Total Number of employees to be covered by this plan

____ Total Number of employees covered by another Blue Cross plan

____ Total Number of employees covered by a plan other than Blue Cross

If interested in **Group Life**, please answer the following:

____ Set amount $____

____ 1 X Salary

____ 2 X Salary

| Employee Name | Occupation | Gender | Date of Birth | Annual earnings | Hours worked per week | Marital Status | Toatal number of Dependents | Number of Dependents over age 19 |
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