

FAX to Carolina Insurance Shopper LLC at 704-987-2132

EMPLOYER CENSUS SHEET

Contact:		DATE:	
COMPANY NAME:		LOCATIONS:	
ADDRESS		PHONE NUMBER:	
CITY:		STATE:	
		ZIP:	
		COUNTY:	
EMPLOYER CONTRIBUTION FOR EMPLOYEE ONLY COST:			(50% REQUIRED MINIMUM)
NUMBER OF ELIGIBLE EMPLOYEES PARTICIPATING:			(75% REQUIRED MINIMUM)
TYPE OF BUSINESS		EFFECTIVE DATE REQUESTED:	

	EMPLOYEE NAMES	EMPLOYEE STATUS*	SEX M/F	DATE OF BIRTH	DEPENDENT STATUS**	Salary & Occupation	ZIP CODES
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							

Emp Status

- * FT: FULL-TIME
- PT: PART-TIME
- CO: COBRA
- WA: WAIVED DUE TO OTHER

Dependent Status

- ** E= EMPLOYEE
- S= EMPLOYEE SPOUSE
- C= EMPLOYEE CHILDREN
- F= EMPLOYEE FAMILY

PLEASE PROVIDE A COPY OF THE LAST INSURANCE BILLING AND ANY MEDICAL CONDITIONS

ALONG WITH A COPY OF YOUR CURRENT PLAN DESCRIPTION