CANON CITY CHAMBER HEALTH PLAN
GROUP CENSUS FORM

In order to provide you quotes that best fit your needs, please complete this form and return via fax to 719.589.4901

Group Name _____ Desired Effective Date _____

City/Zip _____ Requested Plan Design: CHAMBER PRODUCTS

Current Carrier: _____ # of Employees Working > 24 hours/week: _____

Employer Contribution: _____ Employer-Designated Eligibility (in hrs/wk): _____

Total Employees Eligible for Coverage: _____ # of Employees Currently Covered: _____

Contact Person: _____ Contact Phone Number: _____

PLEASE LIST ALL EMPLOYEES WORKING 24 OR MORE HOURS PER WEEK

Employee Name	Date of Birth	Gender	Coverage Type*	Hrs Worked per Week	Eligible for Coverage? y/n	Currently Covered? y/n

I acknowledge all employees listed work 24 or more hours per week and are eligible as determined by employer guidelines.

Coverage Type Key:
1 – employee only
2 – employee + spouse
3 – employee + child(ren)
4 –employee + family
W – waiving coverage

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