Associations Marketing Group, Inc.
Community Action Group Census Information

Name or Business Name ____

Address ______________________________ **City** __________________________________

State _______ **Zip** _________________ **County** ________________ **Tax ID#** ________________________________

Contact Name ________________________ **Phone #** ____________________ **Other Phone** ____________________

Fax (If Applicable) ___________________________ **Email Address** (If Applicable) __________________________________

Current Carrier ___________________________ **# of years**: _________ **Renewal Date** _____________

Dr. Office Co-pay _______ **Deductible**: Single______________ Family_____________ **Co-insurance** ___________

Rx Card_____________ **Out of Pocket Maximum**: Single___________________ Family____________________

Current Rates: EE $ _______ **ES** $ _______ **EC** $ _______ **Family** $ ________ **Monthly Total** $ __________

Renewal Rates: EE $ _______ **ES** $ _______ **EC** $ _______ **Family** $ ________ **Monthly Total** $ __________

Medical Employer Contribution % **EE** _____% **Dependent** ______% **Family** ______%

Total # of Eligible EE's:__________ **Total # of Full Time:**___________ **# of Active Taking Coverage:** ________

Renewal Information: (**Groups over 51 employees**) Please Provide Copy of Recent Renewal

Claims Information: (**Groups over 51 employees**) Please Provide Large Claim Report for Individuals with $10,000 or greater in claims, **Including Diagnosis and Prognosis**:

Does your group offer Retiree Coverage: Yes or No

Number of **Pre-65 Retiree**: _________ Number of **Post 65 Retiree**: _________ Number of **COBRA**: ____________

If filling out this form for a business, please complete the census information below for each employee (More on Back)

Coverage Types - EE=Employee **E/S**=Employee with Spouse **E/C**=Employee with Children **F**=Family

Age	Sex	Coverage Type	Spouses Age	# of Dependent Children

Comments

Ancillary Benefits

(Please circle any ancillary benefit you would like quoted)

Dental **Term Life** **Disability** **Vision** **Wellness Plan** **Cafeteria Plan**

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If filling out this form for a business, please complete the census information below for each employee

Coverage Types - EE=Employee **E/S**=Employee with Spouse **E/C**=Employee with Children **F**=Family

Age	Sex	Coverage Type	Spouses Age	# of Dependent Children

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community Action
PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

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