Pennsylvania
MEDICAL SOCIETY®
PENNSYLVANIA MEDICAL SOCIETY INSURANCE AGENCY

CENSUS INFORMATION SHEET (HEALTH)

Group Name: Group E-mail:	**Have you been a Highmark Blue Shield Customer in the past 25 months? (circle one)** Yes No
Group Phone: Group Fax:	**Current Rates:** **Renewal Rates**:
Address:	Employee: $ $ Employee/Spouse: $ $ Employee/Child(ren): $ $ Family: $ $
Contact Person: Title:	**Current Policy Carrier:** **# Contract Holders**:
Contact Phone: Contact Fax:	**Current Policy Product**:
County:	**Current Policy Renewal Date**:
SIC: 8011	**Effective Date of Prospective Policy**:

Products Interested In: ***(please check all that apply)***

❒ Health ❒ Life ❒ Business Overhead ❒ Worker's Compensation ❒ Disability ❒ Vision ❒ Dental
❒ Long-Term Care ❒ Business Owners Package (Property and General Liability) ❒ Errors and Omissions (E&O)/Directors and Officers (D&O)

*Eligible Employees – those employees that are eligible for health insurance from your group.

PLEASE INCLUDE ALL ELIGIBLE EMPLOYEES* **Employee Name** ***(Indicate if owner)***	**DOB (mm/dd/yy)**	**Gender**	**Contract Type** 1 = Employee 2 = Employee & Spouse 3 = Employee & Child 4 = Employee & Children 5 = Family	**Home Zip Code**	**Employment Status** A = Active (full-time) C = COBRA M = Medicare Primary W = Waiver WR = Waiver (retiree)	**If waiving coverage, name of insurance carrier through spouse**

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