Pennsylvania Medical Society®

PENNSYLVANIA MEDICAL SOCIETY INSURANCE AGENCY

CENSUS INFORMATION SHEET (HEALTH)

Group Name: Group E-mail:	# Contract Holders:
Group Phone: Group Fax:	**Insured with Highmark within Last 18 Months?: Y / N**
Address County:	
Contact Person: Title:	**Current Policy Carrier:**
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)***

❒ Medical ❒ 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	**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**

NOTE: Please return a copy of your practice's UC2 form, or your Schedule C if you are a sole proprietor, along with your completed census form.

P.O. Box 69067 ▪ Harrisburg, PA 17106-9067 ▪ Fax: (717) 561-6077 (Confidential & HIPAA Compliant) ▪ Phone: 866-441-2392

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