



**CENSUS INFORMATION SHEET (HEALTH)**

Group Name:	EIN#:	<b>Have you been a Highmark Blue Shield Customer in the past 12 months? (circle one)</b> Yes      No
Group E-mail:		
Group Phone:	Group Fax:	<b><u>Current Rates:</u></b>
Group Address:		<b><u>Renewal Rates:</u></b>
		Employee:                      \$                      \$
		Employee/Spouse:         \$                      \$
		Employee/Child(ren):    \$                      \$
	Family:                        \$                      \$	
Contact Person:	Title:	<b>Current Policy Carrier:</b>
Contact Phone:	Contact Fax:	<b># Contract Holders Enrolled:</b>
Specialty:		<b>Current Policy Product/Deductible:</b>
Group County:		<b>Current Policy Renewal Date:</b>
SIC: 8011		<b>Effective Date of Prospective Policy:</b>

**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	Home Zip Code	Employment Status	If waiving coverage, name of insurance carrier through spouse
			1 = Employee 2 = Employee & Spouse 3 = Employee & Child 4 = Employee & Children 5 = Family		A = Active (full-time) C = COBRA M = Medicare Primary W = Waiver WR = Waiver (retiree)	

