JSBenefits GROUP
The Employee Benefits Experts

Date: Print Form

Once completed, save this form and email to Info@jsbenefitsgroup.com OR fax to (866) 303-6984

If you have questions, please give us a call at: (877) 355-6070

GROUP CENSUS FORM

PRIMARY CONTACT NAME

GROUP NAME

ADDRESS

CITY STATE ZIP CODE PHONE NUMBER

EMAIL FAX

Information about your plans, and services interested in:

PROPOSED EFFECTIVE DATE: BENEFITS RENEWAL DATE:

CURRENT COVERAGE ☐ Health ☐ Life ☐ Dental ☐ Vision ☐ Disability ☐ Other

CURRENT CARRIER (S)

COMPANY STRUCTURE ◯ Sole Proprietor ◯ Partnership ◯ Corporation LLC ◯ Other

TYPE OF BUSINESS

MORE THAN ONE LOCATION? ☐ YES ☐ NO EMPLOYEES LIVING OUT OF STATE ☐ YES ☐ NO

OF FULL-TIME EMPLOYEES (30+ hrs) # OF COBRA's INDUSTRY SIC CODE

% OF COSTS TO BE PAID BY EMPLOYER EMPLOYEE DEPENDENT (S)

ADD'L INFO:

Please see next page for specific employee information needed. If additional pages are needed, please print blank form and copy.

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GROUP CENSUS FORM *(employee information)*

Enrolling Member	Name	M/F	AGE	DOB	ZIP	COBRA (y/n)

If additional employees spaces are needed, please use next page or copy.

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