



GROUP INSURANCE CENSUS FORM

Company Name: _____
 Company Contact: _____ Type of Business _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Telephone: _____ Fax: _____
 Email: _____

Please list ALL employees who are eligible for health care benefits (work more than 30 hours) and are not already covered on another group plan (usually through their spouse). Use a second sheet if necessary.

Tom Gallanis, LUTCF

GIS Insurance Services

Tom@InsuranceForCA.com

Fax: 888-464-0061 | Office: 800-878-6200

Return this form by fax or email to:

EMPLOYEE				DEPENDENTS		
	Employee Name	M/F	Birthdate or Age	Spouse (Y/N)	Number of Children	Zip Code
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Interested in dental: (Y/N?) _____ \$1000 or _____ \$1500 maximum yearly benefit.

Interested in vision? (Y/N?) _____

Interested in life insurance? (Y/N?) _____

This census accurately represents the employees eligible for health care benefits at this time.

Employer Representative: _____ Date: _____

Helping You Select the Health Plan that Best Fits Your Lifestyle



GIS Insurance Services

Confidential Group Health Insurance

Our approach is to help you select the best Group Health Insurance that meets your needs. In order to address your concerns and streamline the selection process, we compiled a few questions that when answered will allow us to match a plan to your budget and benefits. We appreciate your valuable time for answering each of the questions below and sincerely look forward to serving you and building a long-term relationship. Thank you very much.

Company Name:

Contact:

Tel:

1. Please complete the attached census and provide the following information for your existing plan(s):
2. Briefly explain any concerns or frustrations your group may be experiencing with your current carrier(s), insurance plan(s), brokerage firm or other.
3. Summarize your company's goals, objectives and expectations for this exercise.

4. Provide the following information for your existing plan(s), if no plan write NA if interested enter Q :

Coverage Type	Carrier Name 1	Plan Name 1	Carrier Name 2	Plan Name 2	Renewal Date 1	Renewal Date 2	Mo. Prem. Carrier 1	Mo. Prem. Carrier 2
Medical								
Dental								
Life								
Vision								
Short Term Disability								
Long Term Disability								

5. In order to manage the cost of your benefits program, would you like to: (Choose Letter(s) _____)
 - a. Learn about "Consumer Driven Plans"
 - i. Health Savings Accounts
 - ii. Health Reimbursement Accounts
 - b. Learn about "Employer Defined Contribution" programs
 - c. Learn about "Minimum Premium Funding" (requires 25+ participants)
6. In designing your medical insurance plan, mark "X" your preference from the following options:

Dr. Co pay	\$10	\$15	\$20	\$25	Other
Deductible	\$250	\$500	\$750	\$1000	Other

7. If employees contribute to their premiums or they pay for their dependent costs, are these premiums paid on a (a) Pre-tax or (b) Post-tax basis? (Choose Letter) _____
8. How important is it to offer Kaiser? (Choose Letter) _____
 - a. Not important
 - b. Somewhat important
 - c. Very important

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