



Spangler Insurance Agency

Specializing in Group & Individual Health Insurance

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.

Return this form by fax or email to:
 Spangler Insurance Agency
 Debbie Holt
 Fax: 301-259-9842 or Email: bcbsgal@aol.com
 Please call if you have any questions:
 Office: 301-259-4211 Cell: 301-542-7198

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

(If any employees reside out of state please provide their home zip code)

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



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Interested in short/long term disability insurance? (Y/N)_____

(If yes, please complete the following page regarding specific job title/description & salary so that I may provide you a quote)

Company Taxpayer Type?

C-Corp___ S-Corp___ LLC___ LLP___ Partnership___ Sole Prop___

Please indicate officers or owners of the company.

EMPLOYEE				Census Information For Short/Long Term Disability		
	Employee Name	M/F	Birthdate or Age	Job Title	Description	Salary (per year)
1						
2						
3						
4						
5						
6						
7						
8						
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Confidential Group Health Insurance Field Underwriting Questionnaire

Our approach is to become more intimate with your unique Group Health Insurance needs in order to address your concerns and streamline the bidding process. 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.

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):

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								
401(K)								

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"

6. In designing your medical insurance plan, mark "XXX" your preference from the following options:

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

7. In designing your medical insurance program, would you like to: (Choose Letter) _____
 - a. Offer PPO only
 - b. Offer HMO only
 - c. Offer a combination of HMO *and* PPO plan options
8. 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) _____

This document is Strictly Confidential and its use is regulated by HIPAA guidelines

