CAPITOL
HEALTH MANAGEMENT

Delivering services that make a difference

Once completed, save this form and email to **Info@caphm.com** or fax **to (916) 927-1949**

Date:

Print Form

# GROUP CENSUS FORM

If you have questions, please give us a call at:

(916) 927-6490

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.**

CAPITOL
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# GROUP CENSUS FORM *(employee information)*

| | | M/F | AGE | DOB | ZIP | COBRA (y/n) |
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**If additional employees spaces are needed, please use next page or copy.**

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