Robert Ellis & Associates
Insurance Services

GROUP HEALTH/LIFE INSURANCE PREMIUM INDICATION FORM

Name of **Employer:**		**Type of Business:**
Address:		
City:	State:	Zip:
Phone: ( )	Fax: ( )	E-mail:

If you would like a group life insurance quote to accompany your medical insurance please indicate the benefit amount desired:

❑ $10,000 per employee ❑ $15,000 per employee ❑ $25,000 per employee ❑ Contact me regarding separate benefit levels for me and my staff

NAME	GENDER	DEPENDENT STATUS*	DATE OF BIRTH	SPOUSE DATE OF BIRTH	NUMBER OF CHILDREN

* **E**=Employee only
S=Employee +Spouse
C=Employee +Child(ren)
F=Family

IF YOU EMPLOY MORE THAN 10 INDIVIDUALS, PLEASE COMPLETE AND ATTACH ADDITIONAL COPIES OF THIS CENSUS FORM AS NEEDED.

Printed Name	Date / /
Title	
Signature	

To obtain a health insurance quote for your firm or practice, please complete this Group Census Form and return it by fax to 985-674-3881. Individuals may get a premium indication after completing and submitting the appropriate INDIVIDUAL PREMIUM INDICATION FORM.

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