



# Small Group Employee Census

Requested Effective Date: \_\_\_\_\_  
Agent Name: \_\_\_\_\_

**Completed census can be sent to:**  
Fax completed form to: (262) 754-9560 Attn: Sales  
Email to: Quotes@Commongroundhealthcare.org

## Section I - Group Information

Group Name		
County	State	ZIP Code
ATNE (Average Total Number of Employees Per Year)	Number of Employees You Wish to Add to Quote	
Is your company eligible for the Small Business Health Options Program (SHOP)? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>More information can be found at <a href="http://www.healthcare.gov/small-businesses/choose-and-enroll/qualify-for-shop-marketplace">www.healthcare.gov/small-businesses/choose-and-enroll/qualify-for-shop-marketplace</a></i>		
Do you have any participating employees who reside outside of the 25-county service area (OOA)? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>A list of our 25-county service area can be found at <a href="https://www.commongroundhealthcare.org/service-area/">https://www.commongroundhealthcare.org/service-area/</a></i>		
How did you hear about us?		

\*Coverage Type: EE = Employee, ES = Employee & Spouse, EC = Employee & Child, Fam = Employee, Spouse, & Children

## Section II - Employee Information

Employee Last Name, First Name	*Coverage Type (EE, ES, EC, Fam)	Employee Date of Birth (mm/dd/yy)	Spouse Date of Birth (mm/dd/yy)	Child 1 Age	Child 2 Age	Child 3 Age	Child 4 Age	Child 5 Age	OOA? Y/N

**NEED HELP WITH THIS FORM?** Contact your insurance agent or Common Ground Healthcare Cooperative representative with questions at 888.870.4717.

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