Group Census

TDIC Insurance Solutions
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Note: Please list all Spouse/Partner and Child/Dependent information directly below the Employees's row with whom they are associated. All employees MUST be listed, regardless of eligibility or participation. Any participants who wish to particpate in vision coverage, must request to participate below, and an additional quote will be provide. Adult Vision coverage is not included in base medical benefits.

Company Name

Business Address | City | County | State | Zip

Contact Name | Contact Phone | Contact Email

SAMPLE

Relationship (Employee, Spouse/Partner or Child/ Dependent)	**Job Title**	**First Name**	**Last Name**	**Date of Birth**	**Male/ Female**	**Weekly Hours Worked**	**Home Zip Code**	**Participating (Y/N)**	
								Medical	**Vision**
Employee		*John*	*Smith*	*8/19/64*	*M*	*40*	*95814*	*Y*	*Y*
Spouse/Partner		*Jane*	*Smith*	*7/6/64*	*F*	*30*	*95815*	*Y*	*Y*
Child/Dependent		*Bill*	*Smith*	*1/21/95*	*M*	*10*	*95816*	*Y*	*N*
Child/Dependent		*Susan*	*Smith*	*1/20/97*	*F*	*0*	*95817*	*Y*	*N*

Do you offer current medical coverage? ☐ Yes ☐ No If yes, name of carrier: _____ ☐ HMO ☐ PPO

Total # of employees: _____ # of COBRA participants: _____ Worker's Compensation? ☐ Yes ☐ No

NOTE: Please fax completed form to 877.686.8349 or email to SolutionsLH@cda.org