BUSINESS NAME:	CONTACT NAME:
ADDRESS:	SIC CODE:
PHONE NUMBER:	FAX NUMBER:
EMAIL ADDRESS:	CURRENT INSURANCE COMPANY:

PLEASE SHOW ALL FULL TIME (30 HOURS OR MORE WEEKLY) EMPLOYEES EVEN IF NOT TO BE COVERED

	NAME	EMPLOYEE ZIP CODE	SEX	DATE OF BIRTH	COVERAGE ELECTION **	# OF CHILDREN TO BE COVERED	REASON IF MEDICAL COVERAGE DECLINED **SP=**ON SPOUSE'S GROUP PLAN **IP=**ON INDIVIDUAL PLAN **NC=**NO COVERAGE AT ALL	CURRENTLY ON COBRA (YES OR NO)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								

** **E** = EMPLOYEE; **ES** = EMPLOYEE & SPOUSE; **ESC** = EMPLOYEE, SPOUSE & CHILDREN; **EC** = EMPLOYEE & CHILDREN; **CD** = COVERAGE DECLINED

PLEASE COMPLETE & **FAX** THIS CENSUS FORM TO (630) 985-9701, OR **E-MAIL** IT TO INSURE@CGINSAG.COM

OR **MAIL** IT TO C & G INSURANCE AGENCY, INC; 900 S. FRONTAGE ROAD, SUITE 375; WOODRIDGE, IL 60517

QUESTIONS - CALL (630) 985-9700