EMPLOYEE CENSUS

Employer_____

Mailing Address_____**City**_____**State**_____**Zip**_____

Phone_____ **Email** _____ **FAX**_____

Industry/SIC Code_____**Proposed Effective Date**_____

Current Medical Carrier _____

(Please list all employees(full time-30 hours+ and part time)

Employee Name	Specify Part time Or Full time	Date of Birth/Age	Male/ Female	Residential Zip Code	Type of Contract*	Check if covered through spouse's group plan
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

(If more than 20 employees, please indicate on additional page)

*Type of Contract: EO = Employee Only ES = Employee and Spouse
EC = Employee and Child/(ren) EF = Employee and Family

If full time employee is currently covered through group coverage (not individual coverage) with a spouse please indicate with a check mark.

Please mail or fax to:

Driver Alliant Insurance Services

(Third Party Administration by FHI Benefit Plans, Inc.)

420 S. BROADWAY, ESCONDIDO, CA 92025

PHONE: (800) 347-9547 FAX: (800) 752-6734