



Employee Census Data Form

Employee Census Data Form

Name of Business _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Nature of Business: _____ Current Health Care Plan: _____

Enrollment Guidelines:

- A company with 1-4 employees must enroll 100% of its eligible employees, in one health care plan.
- An “eligible employee” is defined as a full-time employee regularly working 30 or more hours per week (or part-time employee working 20 or more hours per week) and paid in accordance with state and federal wage requirements. Enrollment of part-time employees is not required.
- Full-time employees covered by a spouses health plan may be excluded from coverage.

List **All** full-time and part-time employees (owners included):

If electing Family coverage, please complete the back of this form.

Name	Social Security Number	DOB	Individual (I) Couple (C) Family (F)	Covered by Spouse's Health Plan?		Hours	Status
				Yes	No		

I certify that the list above represents all people employed by this company. I understand that Blue Cross and Blue shield or its agent may examine the group’s payroll and other records at any reasonable time while this group’s insurance is in effect.

Name (please print) _____

Signature _____ Title: _____

Please Forward to: Blue Cross Blue Shield-
 Small Group Sales, 01/06
 Landmark Center
 401 Park Drive
 Boston, MA 02215-3326
 Or Fax: 617-246-3633
 Telephone: 1-800-422-3545

Status Codes:
 B- Enrolling in Blue Cross Blue Shield
 S- Covered under spouse’s insurance
 P- On probationary period
 PT- Part-time