



HEALTH ▲ LIFE ▲ DENTAL ▲ DISABILITY ▲ VISION ▲ GROUP AND VOLUNTARY

Group Census

Group Name: _____
 Physical Address, City, ST Zip: _____
 Phone Number: _____ Email: _____
 Contact Person – Title: _____
 Current Carrier: _____ Renewal Date: _____

Select the group coverage(s) you would like quoted:

- Health Dental Life Disability (must include salaries / occupation)

Please complete this form and you can either email it to carroll@carolina.rr.com or print it out and fax it to us at 704-543-9612.

	Employee Name	Sex	DOB	Covering Spouse Y or N	# of Deps (if covering)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

Questions? Call us in the office at 704-543-9314.