EMPLOYER CENSUS FORM

PacAdvantage

FAX ALL QUOTE REQUESTS TO 916.786.5760

PACADVANTAGE ID NUMBER

DESIRED EFFECTIVE DATE

EXACT LEGAL NAME OF COMPANY

AGENT'S NAME

DOING BUSINESS AS (DBA)

AGENT'S PHONE NUMBER

MAILING ADDRESS

AGENT'S LICENSE NUMBER

CITY STATE ZIP GROUP PHONE NUMBER

GROUP CONTACT PERSON

QUOTE RETURN OPTIONS ☐ US MAIL ☐ FAX ☐ E-MAIL

ORDER REQUESTS

__ **Paired Choice Quote** ___ **PacAdvantage Pool Quote** ___ **Quote both products**

THE FOLLOWING INFORMATION WILL DETERMINE GROUP SIZE RATE DIFFERENTIAL

HOW MANY **ELIGIBLE** EMPLOYEES AT TIME OF APPLICATION? _____ (**ELIGIBLE** EMPLOYEES ARE EMPLOYEES WHO ARE ENROLLING OR DECLINING ONLY.)

EMPLOYERS ARE REQUIRED TO CONTRIBUTE 50% OF THE AVERAGE OF THE GROUP'S PREMIUM FOR ALL ENROLLED EMPLOYEES BASED ON THE LOWEST AVAILABLE EMPLOYEE-ONLY RATE.

QUOTE CAN BE PROCESSED WITH THE FOLLOWING OPTIONS

EMPLOYER CONTRIBUTION OPTIONS	**MEDICAL**		**DENTAL** (IF APPLICABLE)		**VISION** (IF APPLICABLE)		**CAM** (IF APPLICABLE)	
	EE	**DEP**	**EE**	**DEP**	**EE**	**DEP**	**EE**	**DEP**
PERCENTAGE (%) OF LOWEST COST HMO PLAN	%	%						
FLAT DOLLAR ($) AMOUNT	$	$	$	$	$	$	$	$
PERCENTAGE (%) OF PREMIUM FOR A SPECIFIED PLAN	%	%	%	%	%	%	%	%
SPECIFIED PLAN								
PERCENTAGE (%) OF LOWEST COST PLAN	%	%	%	%	%	%	%	%

2901 DOUGLAS BOULEVARD • SUITE 305 • ROSEVILLE • CALIFORNIA 95661
877.735.5742

QUOTE REQUEST WILL BE PROCESSED WITHIN 24 TO 48 HOURS

EMPLOYER CENSUS FORM

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COMPLETE CENSUS FORM

PLEASE PRINT ALL INFORMATION

EE = EMPLOYEE ONLY
ES = EMPLOYEE AND SPOUSE/DOMESTIC PARTNER
EC = EMPLOYEE AND CHILD(REN)
FA = FAMILY

	NAME OF EMPLOYEE	DATE OF BIRTH	COVERAGE LEVEL				HOME ZIP CODE
			EE	ES	EC	FA	
1							
2							
3							
4							
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