



Legal Business Name: _____
 Business Name (DBA): _____
 Contact Name: _____
 Street Address: _____
 City/State/Zip: _____
 Phone: _____

FHCP Plans of Interest HMO, POS, Triple Option: _____
 Effective Date: _____ Federal Tax ID: _____
 # of Eligible Employees: _____ SIC Code: _____

SMALL GROUP CENSUS FORM - 2 TO 50 ONLY

EMPLOYEE #	MEMBER STATUS	LAST NAME	FIRST NAME	DATE OF BIRTH	EMPLOYEE SS #	DEPENDENT SS #	GENDER	ADDRESS	HOME ZIP CODE	COUNTY	HIRE DATE	EMPLOYMENT STATUS KEY	TOBACCO STATUS KEY	COVERAGE STATUS
1	Employee	Jane	Doe	10/14/64	500-00-0000	600-00-0000		1234 Health Lane Daytona Beach	32114	Volusia	1/1/24	0 Active	1 Yes	1 Waive/Covered elsewhere
2														
3														
4														
5														
6														
7														
8														

Agent Name: _____
 Agent Phone #: _____
 Agent Email Address: _____
 Date Requested: _____
 Quote Needed by: _____

MEMBER STATUS KEY	EMPLOYMENT STATUS KEY	TOBACCO STATUS KEY	COUNTY	COVERAGE STATUS
ID/Name	ID/Name	ID/Name		ID/Name
Employee Spouse/DP Child	0 Active 1 COBRA 2 FL-COBRA 3 Waiting Period 4 Part Time	1 - Yes 2 - No	Volusia Flagler Seminole	0 - Waive/No Other Coverage 1 - Waive/Covered elsewhere 2 - Enroll