



# CENSUS

The purpose of this form is to provide general background information to NARFA. All information will remain confidential. More than one policy is required for a group health insurance quote. Please complete the information below and mail it in the enclosed envelope. A NARFA representative will call you to review your quote. If you have any questions, please contact us at the numbers or email below, or go to [www.narfa.com](http://www.narfa.com).

Company Name \_\_\_\_\_

Contact \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

Current Carrier \_\_\_\_\_ Renewal Date \_\_\_\_\_

Monthly Single Rate \_\_\_\_\_ Monthly Employee / Spouse Rate \_\_\_\_\_ Monthly Employee / Child Rate \_\_\_\_\_ Monthly Family Rate \_\_\_\_\_

Renewal Monthly Single Rate \_\_\_\_\_ Renewal Monthly Employee / Spouse Rate \_\_\_\_\_

Renewal Monthly Employee / Child Rate \_\_\_\_\_ Renewal Monthly Family Rate \_\_\_\_\_

Total Number of Employees Eligible for Benefits \_\_\_\_\_

EMPLOYEE NAME	EMPLOYEE DEPENDENTS	GENDER	DATE OF BIRTH	COVERAGE TYPE*	FULL-TIME/PART-TIME	ZIP CODE
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

\*Coverage Type: 1-Employee, 2-Emp/Spouse, 3 -Emp/Children, 4-Emp/Family, O-Other Coverage, W-Waiving Coverage

**Thank you for your time – we look forward to working with you!**

Please photocopy this form for additional space.