



**BEST VALUE
INSURANCE
AGENCY, INC.**

1700 S. Campbell, Suite C
Springfield, MO 65807
Office: (417) 863-1096
Fax: (417) 863-8640
groupmarket@bvai.com

www.einsureforless.com

Group Census Form for a Group Health Insurance Quote

Name of business		Nature of Business/SIC Code		
Address	City	County	St	Zip
Phone () -	Fax () -	Person to Contact		
Current Group Carrier/Agent	Current Premium \$	Time in Force		
Carriers To Quote:				

Group Plan Selections (Important, ALL questions must be answered)

If we provide you better coverage with a better rate will we get your business? Yes No

Plan Type: NON-PPO PPO HMO HSA

Preferred deductible: \$ _____

Preferred stop loss: \$ _____

Preferred Network/Hospital: _____

Dr. co-pay: \$10 \$20 Other \$ _____

% of premium employer contributes to employee _____%

Dependent Premium _____%

Total # of full time employees _____

RX drug card Yes No

Supplemental
accident Yes No Amt. \$ _____

Maternity Yes No

Dental Yes No

Vision Yes No

Group life: No Yes, Amt. \$ _____

Dependent life: No Yes, Amt. \$ _____

Final Decision maker _____

EMPLOYEE INFORMATION

Name	Gender (M/F)	Age or DOB	Cover- age see below*	Spouse age if applying	Number of Children	ANY known medical conditions. (Use back if necessary)	Tobacco Yes/No
1.							
2.							
3.							

* EE=Emp. only, ES=Emp. & spouse, EC=Emp.w/child, FA=Family, L=Life only



HEALTH • LIFE • SENIOR PRODUCTS
ANNUITIES • RETIREMENT ACCOUNTS



Name	Gender (M/F)	Age or DOB	Coverage see below*	Spouse age if applying	Number of Children	ANY known medical conditions. Use separate paper if necessary.	Tobacco Yes/No
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