



CCINW BENEFIT INSURANCE PROGRAM

Health & Dental Employee Census



Client Name: _____ Phone# _____
 Address _____ Fax# _____
 Previous Carrier _____ Benefit Contact _____
 New Hire Probationary Period _____ SIC Code 7217 (Carpet/Uphol. Cleaning)
 #Weekly hours to be considered full time (17.5 up to 40 hrs) _____
 Total Full Time Employees _____ Type of Business _____
 Total Part Time Employees _____ Eligible Full Time Employees _____
 Employer Contributes _____ % Toward Employee Premium _____ % Toward Dependant Premium
 Effective Date: _____

#	Employee Name	Sex	Date of Birth	Date of Hire	Dependent Status*	# of Children	Waiving Coverage?	Zip Code
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.								

<p>*Dependent Status EE – Single ES – Employee & Spouse EC – Employee & Children F – Full Family</p>	<p>Please return this form to: 5100 SW Macadam Avenue, Suite 270 Portland, OR 97239 or you may fax to (503) 972-7310 or you may email to alvin.ochosa@hrh.com Attach Additional Sheets if Necessary PLEASE ATTACH A COPY OF THE CURRENT BENEFIT PLAN DESIGN AND RATES</p>
--	---

