40 Square Health Plan Employer Census Intake Form

Requested Effective Date:	
Employer/Business Name:	
Nature of Business:	
Employer Street Address:	
City:	
State:	
Zip:	
Total Full-Time Employees:	
Total Employees to be Quoted:	
Broker Name:	

Please list all employees, spouse and dependent children to be quoted. Medical Questionnaires are also required for a firm proposal.

#	Member's Last Name	Member's First Name	Relation	Date of Birth	Gender	Quote	Valid Waiver*	Waive (no other coverage)
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The census form can be emailed to the info@ 40square.coop or faxed to 507-216-0377.