Census Form

CENSUS INFORMATION (NAME OF COMPANY):

PROVIDED BY (NAME OF AGENT):

BE SURE TO ATTACH REQUIRED CENSUS ON ALL ACTIVE EMPLOYEES WORKING 24 OR MORE HOURS PER WEEK.

SPECIAL NOTES: If persons other than those working 24 hours or more per week are eligible for coverage (examples: retirees, partners, board members) these members must be specifically identified and underwriting approval obtained. Additional documentation will be required.

For groups of 100 or more employees, contact your assigned Blue Cross and Blue Shield of Oklahoma Account Executive. Additional required items for a large group quote include monthly claims and premiums for the past 2 years, monthly enrollment counts for the past 2 years, copy of current benefit booklet, copy of current billing, as well as information on any administrative fees, stop-loss levels and premiums for any non-traditional arrangements. Likewise, disability quotes for groups of 100 or more employees require premium and claims data for the past 2 years and groups of 500 or more employees require premium and claims data for 5 years (life and disability.) You certify, with submission, that, to the best of your knowledge, the information provided is complete and true. You understand that Blue Cross and Blue Shield of Oklahoma relies on the information provided in this questionnaire and reserves the right to retroactively cancel the group's policy if fraudulent information is provided to Blue Cross and Blue Shield of Oklahoma.

THANK YOU FOR DOING BUSINESS WITH BLUE CROSS AND BLUE SHIELD OF OKLAHOMA. WE LOOK FORWARD TO WORKING WITH YOU ON THIS PROPOSAL!

CENSUS INFORMATION

PLEASE COMPLETE THIS CENSUS FOR ALL ACTIVE EMPLOYEES WORKING 24 OR MORE HOURS PER WEEK. COBRA ENROLLEES, OR EMPLOYEES WITH SPECIAL STATUS SUCH AS ABSENCE OR WORKERS' COMPENSATION LEAVE, PLEASE PROVIDE SEPARATE EXPLANATIONS FOR ANY HEALTH PLAN MEMBERS NOT WORKING 24 OR MORE HOURS PER WEEK. YOU MAY USE YOUR OWN FORM IF IT CONTAINS REQUESTED INFORMATION.

NAME	WORK LOCATION (TULSA, OK CITY, ETC.)	GENDER (M OR F)	BIRTH DATE OF EMPLOYEE	BIRTH DATE OF SPOUSE	COVERED BY CURRENT PLAN	HEALTH PLAN ENROLLED STATUS (EMPLOYEE ONLY, EMPLOYEE AND SPOUSE, EMPLOYEE AND CHILDREN, FAMILY)	IF COBRA ENROLLED, GIVE DATE COBRA COVERAGE WAS EFFECTIVE	SALARY, FOR LIFE QUOTES BASED ON SALARY AND DISABILITY QUOTES

NOTE: ATTACH MULTIPLE COPIES AS NEEDED FOR LARGER GROUPS