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Census Data for Employee Benefits Proposal

Client Information:				
Business Name:			DBA:	
Address:		City,	, State, Zip:	
Phone:			Fax:	
Contact Name:			Email:	
Nature of Business:			SIC Code:	
Other locations:			Tax ID:	
Business Structure:				
	Sole Proprietor	C-Corporation		Limited Liability Corporation
	S-Corporation	Partnership		Other:
Place provide the following inform	nation			

Please provide the following information:

*Insurance summaries (medical, dental, vision, life, disability, etc | *Recent billing statements | *Renewal letter w/rates

Current/Requested Benefit Plans:

		Effective	Employer Contribution	Employer Contribution for
Plan Type	Vendor	Date	for Employee	Dependents
Medical Insurance				
Dental Insurance				
Vision Insurance				
Life Insurance				
Disability Insurance				
Section 125 Plan				
HRA and/or HSA				
Retirement Plan				
Supplementary Plans				

ll employees, spouses and children						Enrollme	ent Status (EO,E	S,EC,EF)	For Disability Only		
Na Last	ame First	Status Employee Spouse / Child	Gender M/F	DOB	Home Zip Code	Full-Time Part-Time 1099	Medical Coverage	Dental Coverage	Vision Coverage	Comp. Last Year	Occupation Duties

*Use the following abbreviations to when entering your Medical, Dental or Vision coverage.

Employee Only = EO

Employee & Child(ren) = EC

Employee & Spouse = ES

Employee & Family = EF

Declining Coverage = DC

Waiting Period = WP

Covered Elsewhere = CE