

TDA GROUP INSURANCE PLANS CENSUS FORM

Complete and fax to (423) 629-1109 or mail to: Plan Administrator • P.O. Box 1109 • Chattanooga, TN 37401-1109

Practice Name _____

Primary Contact _____ Title _____

Street Address _____

City/State/Zip Code _____

Phone Number (_____) _____ Fax Number (_____) _____

E-mail Address _____

Please indicate the desired group plan(s) you would like a proposal for:

	Current Carrier	Renewal Date
<input type="checkbox"/> Group Life	_____	_____
<input type="checkbox"/> Group Health	_____	_____
<input type="checkbox"/> Group Long Term Care	_____	_____
<input type="checkbox"/> Group Long Term Disability	_____	_____
<input type="checkbox"/> Group Short Term Disability	_____	_____
<input type="checkbox"/> Workers' Compensation Plan	_____	_____

Complete the information below on all employees. Please indicate the type of medical coverage currently in force for each employee. If more space is needed, please include a separate sheet.

Name	Occupation	Date of Birth	Sex	W-2 Annual Earnings*	Check below, indicating who is covered. If spouse is covered, indicate year of birth.
1					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
2					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
3					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
4					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
5					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
6					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
7					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
8					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
9					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
10					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
11					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
12					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
13					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
14					___ Employee ___ Spouse-birth yr. ___ No. of Children ___
15					___ Employee ___ Spouse-birth yr. ___ No. of Children ___

*Complete this column ONLY if you would like a disability insurance or workers' compensation proposal.

Please indicate here if you would like information on other plans or services:

Professional Liability Insurance
 Business Office Package
 Voluntary Payroll Deduction Plans
 Section 125 Cafeteria Administration
 Comprehensive Insurance Review Service