

Employer Group Census Form

Claims Administrator:
Consociate • Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Employer Information (please type or print)

Employer: _____ Current Group Health Insurance Carrier: _____ % / _____ %
 Company Contact: _____ Current Deductible: _____ In/Out of network co-insurance: _____
 Street: _____ Current Additional Coverages (dental, vision, STD): _____
 City: _____ State: _____ Zip: _____ Current plan renewal date: _____
 Phone: _____ Fax: _____ E-mail: _____
 Total number of full-time active employees (include collectively bargained employees): _____
 Total number of eligible employees (full-time employees not covered by collective bargaining): _____
 Total number of employees enrolling in AGC Health Plan: _____

	Employee Name	M/F	Employee Age	Spouse's Age	Dependent Coverage*	Number of Children	Amount of Life Ins. \$4,000 minimum	Indicate if COBRA or Retiree
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

*Dependent Coverage: **EM**=Employee Only **ES**=Employee and Spouse **EC**=Employee and Child(ren) **EF**=Full Family

Minimum Participation Levels Are As Follows

Number of Full-Time Non-Collectively Bargained Employees	Minimum # Employees Needed to be Covered under AGC Health Plan	# of Employees not Covered by AGC Health Plan that must have valid major medical Coverage elsewhere
2	2	0
3	2	1
4	2	2
5	3	1
6	3	2
7	4	2
8	4	3

For nine (9) and above, 70% of all full-time employees must be covered by the Plan or have valid waivers, but in no case shall less than 50% of all eligible full-time (30 hours per week or more) employees be covered on the Plan.



Employer Group Census Form (continued)

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Employer Information (please type or print)

Employer: _____

	Employee Name	M/F	Employee Age	Spouse's Age	Dependent Coverage*	Number of Children	Amount of Life Ins. \$4,000 minimum	Indicate if COBRA or Retiree
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
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*Dependent Coverage: **EM**=Employee Only **ES**=Employee and Spouse **EC**=Employee and Child(ren) **EF**=Full Family

Minimum Participation Levels Are As Follows

Number of Full-Time Non-Collectively Bargained Employees	Minimum # Employees Needed to be Covered under AGC Health Plan	# of Employees not Covered by AGC Health Plan that must have valid major medical Coverage elsewhere
2	2	0
3	2	1
4	2	2
5	3	1
6	3	2
7	4	2
8	4	3

For nine (9) and above, 70% of all full-time employees must be covered by the Plan or have valid waivers, but in no case shall less than 50% of all eligible full-time (30 hours per week or more) employees be covered on the Plan.

