Benefit Design Management
Census Form Directions

TO GET A QUOTE

Fax Completed Form To:
Benefit Design Management
Fax: (856) 589-6444

_____
Company Name

_____

_____

_____
Address

_____
Phone

_____
Fax

_____
Nature of Business

Type of Coverage Requested

HMO:
Copay: $5___ $10___ $15___ $20___
Rx: $5/$10___ $15___ 50%___
Hospital Copay: Yes___ No___

PPO:
Copay: $10___ $20___
Rx: $5/10__ $15__ 50%__ None__
Out of Network Deductible: $250__ $500__ $1000__
Out of Network Coinsurance: 70%__ 80%__

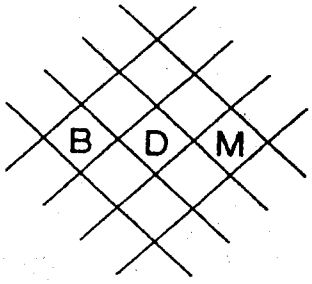
POS:
Copay: $5___ $10___ $15___ $20___
Rx: $5/$10___ $15___ 50%___ None____
Out of Network Deductible: $250__ $500__ $1000__
Out of Network Coinsurance: 70%__ 80%__

Dental: Yes:____ No:____

Vision: Yes:____ No: ____

Group Term Life: Yes:____ No: ____

Long Term Disability: Yes:____ No:____



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Phone: (856) 589-6565 **Fax:** (856) 589-6444

NAME	SEX	BIRTH DATE or AGE	STATUS	OCCUPATION

STATUS: S = Single P/C = Parent/Child H/W = Husband/Wife F = Family