

# Gardner Insurance, Inc.

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971.223.5166 or 1.866.511.7975

Please return this form to Fax # 971.223.5228

## Employee Census Form

Name of Group \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
 Type of Industry \_\_\_\_\_  
 Current Medical Carrier \_\_\_\_\_ Deductible \_\_\_\_\_

Please list all eligible employees (those working 17.5 hours per week or more)

Employee Last name	M/F	Date Of Birth	Dependents		Date of Hire	Hours Per Week	Eligible Y/N	Not Enrolling	Zip Code
			Spouse	# of Children					
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

If more than 12 employees please use 2 forms