



**COLORADO CHOICE HEALTH PLANS  
GROUP CENSUS FORM**

Group Name \_\_\_\_\_ City/Zip \_\_\_\_\_

Desired Effective Date \_\_\_\_\_ Requested Plan Design: Chaffee Chamber

Current Carrier: \_\_\_\_\_ # of Employees Currently Covered: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

*PLEASE LIST ALL EMPLOYEES WORKING 24 OR MORE HOURS PER WEEK*

	<b>Employee Name</b>	<b>Date of Birth</b>	<b>Coverage Type*</b>
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

**I acknowledge all employees listed work 24 or more hours per week and are eligible as determined by employer guidelines.**

**\*Coverage Type Key:**

- 1 – employee only**
- 2 – employee + spouse**
- 3 – employee + child(ren)**
- 4 – employee + family**
- W – waiving coverage**

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