CHC
Carolina Health Connections
PO Box 273 · Fort Mill, SC · 29716
PH: 704-512-0600 FAX: 803-336-2300

Carolina Health Connections agent: _____ Date: _____

Company Name: _____ Employer Tax ID: _____
Physical Address: _____ City: _____ State: _____ County: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ County: _____ Zip: _____
Phone: _____ Fax: _____ Executive (owner,president): _____
Contact Person: _____ Alt. Phone: _____ Email: _____
Nature of Business: _____ SIC Code: _____ Type of Legal Entity (Corp, Partnership,etc): _____

Do you file quarterly wage reports? _____ How often do you pay your employees? _____
Number of Employees: F/T W-2 Males: _____ F/T W-2 Females: _____ Part Time: _____ 1099 : _____ Seasonal/Temp: _____
Are you a member of a Chamber of Commerce? _____ If yes, which one? _____
Do you have Worker's Comp? _____ If yes, with what company? _____ If no, would you like a quote? _____
Waiting period for new hires: 0 ____ 30 ____ 60 ____ 90 ____ Termination date: Last day worked ____ Last day of month ____

HEALTH

Current Carrier: _____ Effective Date: _____ Renewal Date: _____
Current Benefits, Plan 1: Deductible: _____ Coinsurance: _____ Out of Pocket: _____ Copays: _____
Current Benefits, Plan 2: Deductible: _____ Coinsurance: _____ Out of Pocket: _____ Copays: _____
If more than one plan is offered, please indicate on the census which plan each employee is currently taking.
How much will you pay towards the premiums? Employee: _____ Dependents: _____

LIFE

Current Carrier: _____ Effective Date: _____ Renewal Date: _____
Employee Benefit: ALL EMPLOYEES: $ _____ **OR** CLASS: _____ Dep Life: _____
How much will you pay towards the premiums? Employee: _____ Dependents: _____

DENTAL

Current Carrier: _____ Effective Date: _____ Renewal Date: _____
Current Benefits: Deductible: _____ Preventive %: _____ Basic %: _____ Major %: _____ Ortho? _____ Annual Max: _____
How much will you pay towards the premiums? Employee: _____ Dependents: _____

VISION

Current Carrier: _____ Effective Date: _____ Renewal Date: _____
Exam Freq & Cost: _____ Materials: _____ Frames: _____ Contacts: _____
How much will you pay towards the premiums? Employee: _____ Dependents: _____

STD

Current Carrier: _____ Effective Date: _____ Renewal Date: _____
Benefits begin (days): Accident: ____ Illness: ____ Duration of Benefits: (weeks) _____ Weekly Benefit: _____
How much will you pay towards the premiums? _____

LTD

Current Carrier: _____ Effective Date: _____ Renewal Date: _____
Elimination period (days): _____ Duration of benefits (yrs): _____ Monthly Benefit: _____ Max Benefit: _____
How much will you pay towards the premiums? _____

REQUESTED EFFECTIVE DATE:

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***** FOR HIPAA PURPOSES, PLEASE RETURN BY SECURE EMAIL OR FAX TO 803-336-2300. ONLY RETURN VIA SECURED EMAIL. *****

BUSINESS NAME: _____ **AGENT:** _____ **DATE:** _____

	Member Class	Last Name	First Name	Last 4 SSN	Home Zip Code	Date of Birth	Gender	Use Tobacco	Work Status	Date of Hire	Annual Salary	$ per hour for Hourly	Employee Email
1													
2													
3													
4													
5													
6													
7													
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11													
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AGENT NAME: *Maria Overcash*

KEY FOR CENSUS WORKSHEET:

Current **Plan Option** (if more than one)	
1	N/A
2	N/A

Member Class	
SA	Salaried
HR	Hourly

Coverage Tier	
EE	Employee Only
ES	Employee + Spouse
EC	Employee + Child(ren)
EF	Employee + Sp + Ch
Waive	Valid Waiver
Decline	Declining Coverage
WP	In Waiting Period

Reason for Waiving
Spouse's plan
Parents' plan
Military / VA
Medicare
Medicaid
Other: Explain

Work Status
Full Time
Part Time
Seasonal
Continuation/COBRA

Tobacco Use
Y Yes
N No

Carolina Health Connections, LLC collects personal information directly from our clients. However, we may collect your information from other sources with your consent or as authorized by law. Only the personal information needed to provide services to our clients is requested. The services include, but are not limited to, enrollment, application, and consideration for benefit programs or policies. Personal information means information about an identifiable individual. This includes an individual's name, home address and phone number, age, sex, marital or family status, and identifying number or financial information. We protect personal information in a manner appropriate for the sensitivity of the information following HIPAA laws. We make every reasonable effort to prevent any loss, misuse, disclosure or modification of personal infomation, as well an any unauthorized access to personal information. We use appropriate security measures when destroying person information, including shredding paper records and permanently deleting electronic records. This information is never sold.