tda Insurance AGENCY, INC.

HEALTH BENEFITS PLAN CENSUS FORM

Group Name: _____

Company Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Contact Person: _____

Phone: _____ **Fax:** _____

Email: _____

Effective Date: _____ **Number of Subscribers:** _____ **Trust:** TDCBT

#	Name	Date of Birth MM/DD/YYYY	Gender M or F	Tier* EE, EC, ES, Fam	5-Digit Zip Must Provide Home Zip
1					
2					
3					
4					
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6					
7					
8					
9					
10					
11					
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14					
15					
16					
17					
18					
19					
20					

***Tier: EE** = Employee Only **EC** = Employee + Child(ren) **ES** = Employee + Spouse **Fam** = Family

Phone: 800.347.1109 | Fax: 866.791.2806 | TDA@assoc-admin.com