piag
Insurance Services

PIAG INSURANCE SERVICES

Medical Census Quote

YOU MAY SUBMIT THIS FORM ELECTRONICALLY. For your convenience, this form is fillable in Acrobat and may be submitted electronically. Save the file when completed and email to Patsy Baugus at patsyb@piag.org. To submit via fax, print and send to: 770.433.3066.

General Info

Company Name:______________________________ Address:____________________ City/State/Zip:______________________

Phone Number:___________ Fax Number:_________ Contact Person:______________ County:_________ Type of Business:____________

Current Carrier:___________________ Effective Date:_______________ # of Employees on Payroll FT:______ PT:______ Seasonal:_______

Employer Contributions

Employee: What amount/percent do you pay for your employee's health premium? _______________________

Dependent: What amount/percent do you pay for the dependent's health premium? _______________________

Employee Information

Employee	Sex	Age/ DOB	Status Code*	Spouse's DOB	# of Children	Child #1			Child #2			Child #3			ZIP
						Sex	Name	DOB	Sex	Name	DOB	Sex	Name	DOB	

*Enter the code to indicate the type of coverage your employees currently have: Employee = E Employee & Spouse = ES Employee & Child(ren) = EC Employee & Family = EF Waiving Coverage = W

Does your company offer Section 125 where employees pay their portion of the premiums with pre-tax dollars? ❑ Yes ❑ No

This service can be offered to you at no cost when signing up for our health benefit programs.