Small Group Census

TDIC Insurance Solutions
1201 K Street, 17th Floor, Sacramento, CA 95814
800.733.0633 tdicinsurance.com

DATE: _____

NOTE: Email completed form to: healthenrollment@tdicins.com or FAX 877.741.1063

Company Name

Business Address | City | State | Zip

Contact Name | Contact Phone | Contact Email

Do you offer current group medical coverage? ☑ Yes ☐ No If yes, name of carrier: _____

Type of plan: ____ HSA ____ HMO ____EPO ____ PPO Do you offer Vision? _____ Dental _____

Total # of employees: _____ Full Time (30+ hrs.): _____ Part Time (20+ hrs.): _____

# of COBRA participants: _____ Workers Compensation? ☑ Yes ☐ No

***Select all carriers, plans types and metal tiers you would like quoted.**

Carriers:

- ☐ Aetna
- ☐ Anthem Blue Cross
- ☐ Blue Shield of CA
- ☐ California Choice (Private Exchange)
- ☐ Health Net
- ☐ Kaiser
- ☐ Oscar*
- ☐ Sharp*
- ☐ Sutter Health Plus *
- ☐ UnitedHealthcare
- ☐ Western Health Advantage *

*NOT Available in all Regions.

Plan Type:

- ☐ HSA
- ☐ HMO
- ☐ EPO*
- ☐ PPO/POS

Metal Tier:

- ☐ Bronze
- ☐ Silver
- ☐ Gold
- ☐ Platinum

*NOT Available for all Carriers.

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Note: Please list all Spouse/Partner and Child/Dependent information directly below the Employees's row with whom they are associated. **All employees MUST be listed**, regardless of eligibility or participation. Any participants who wish to particpate in vision coverage, must request to participate below, and an additional quote will be provided. Adult Vision coverage is not included in base medical benefits.

SAMPLE

Relationship (Employee, Spouse/Partner or Child/ Dependent)	**Job Title**	**First Name**	**Last Name**	**Date of Birth**	**Male/ Female**	**Weekly Hours Worked**	**Home Zip Code**	**Participating (Y/N)**	
								Medical	**Vision**
Employee	*Office Assistant*	*John*	*Smith*	*8/19/64*	*M*	*40*	*95814*	*Y*	*Y*

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