



BE Solutions Employee Medical Benefit Census Questionnaire

Company Name:

Address:

County:

Employee Name:

Employee Date of Birth:

Sex: Female Male

Tobacco: Yes No

Electing Medical Coverage: Yes No

Coverage: Employee Employee & Spouse Employee & Child(ren) Family Life Only

Work Status: Full Time

Part Time

Occupation/Title:

Address:

City:

St.: Zip:

Hire Date:

Marital Status:

Spouse Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No

Child Name:

DOB:

Sex: Female Male Tobacco: Yes No