

**EMPLOYEE CENSUS FORM FOR:** \_\_\_\_\_

Address, street, city, state, zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Please fax back to the ELEA Benefits Administrators, Nancy Bond Insurance Services, 626/599-8579  
Call with questions 866/899-8559**

Emp .	Name, last, first	M/F	Birthdate	Spouse Y/N	No. Of Children	Home Zip	Annual Salary	Job Title
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								

Notes: 1. Please include your "eligible" employees. **Eligible** means they do NOT have other Medical coverage on their Spouse or Parents GROUP medical policy. Include spouse or children only if coverage is requested. 2. Do you currently have any group employee benefits? \_\_\_\_\_  
If so, please give the name of your carrier and the type of plans: \_\_\_\_\_

Nancy Bond Insurance Services  
201 West Lemon Avenue, Monrovia, CA 91016