

**Cognizant Benefits Solutions, Inc.**

**Phone: 724-285-6446**

**FAX: 724-283-1367**

**singalls@cognizantbenefitssolutions.com**

**REQUEST FOR INFORMATION**

To request a proposal please complete the following and fax to Cognizant Benefits Solutions at 724-283-1367.

Company Name		# Eligible Employees		# Covered Employees	
Address		City		Zip	
Contact Name		Title			
Phone		Fax			
Type of Business		SIC (if known)		Current insurance company:	
Rates: Employee Only \$	Employee + Child \$	Employee + Children \$	Employee – spouse \$	Employee – family \$	

**EMPLOYEE CENSUS**

Please include with this form your employee census. List only full-time employees including employees waiving coverage, on disability, and COBRA. If you have more employees than can be listed on this form, please list employee census separately and fax with this form.

	Name	Date of Birth	Gender M / F	Coverage Status	Number of Children'
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

**COVERAGE STATUS:**

Individual - (I)

Employee and Spouse – (ES)

Employee and Child or Children – (EC)

Family –(F)