NARFA
NATIONAL AUTOMOTIVE
ROADS & FUEL ASSOCIATION

CENSUS

The purpose of this form is to provide general background information to NARFA. All information will remain confidential. More than one policy is required for a group health insurance quote. Please complete the information below and mail it in the enclosed envelope. A NARFA representative will call you to review your quote. If you have any questions, please contact us at the numbers or email below, or go to www.narfa.com.

Company Name _____

EIN _____

Contact _____

Phone _____

Fax _____

Email _____

Address _____

Current Carrier _____ Renewal Date _____

Monthly Single Rate _____ Monthly Employee / Spouse Rate _____ Monthly Employee / Child Rate _____ Monthly Family Rate _____

Renewal Monthly Single Rate _____ Renewal Monthly Employee / Spouse Rate _____

Renewal Monthly Employee / Child Rate _____ Renewal Monthly Family Rate _____

Total Number of Employees Eligible for Benefits _____

EMPLOYEE NAME	EMPLOYEE DEPENDENTS	GENDER	DATE OF BIRTH	COVERAGE TYPE*	FULL-TIME/ PART-TIME	ZIP CODE

*Coverage Type: 1-Employee, 2-Emp/Spouse, 3 -Emp/Children, 4-Emp/Family, O-Other Coverage, W-Waiving Coverage

Thank you for your time – we look forward to working with you!

Please photocopy this form for additional space.

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