

Group Name: _____
Street Address: _____
City, State, Zip: _____
Group Phone Number: _____
County: _____
SIC Code: _____
Total Employees including Part-time _____

***Coverage Codes:** S - Emp, EC - Emp/Child, ECN - Emp/Children, ES- Emp/Spouse, F -Family, W - Waive, RT - Retired, IE - Ineligible

	<u>Employee Name</u>	<u>M/F</u>	<u>DOB**</u>	<u>Age</u>	<u>Medical Coverage*</u>	<u>Spouse's DOB</u>	<u># of Kids</u>	<u>Zip</u>	<u>Active, COBRA or Retired</u>	<u>Medicare Y-N</u>
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**** For any employees over 65, please also list the spouse's date of birth**