Company Name: _____
Effective Date: _____
Contact name, title: _____
Phone Number: _____
Email: _____

Previous Coverage? No
Carrier: _____
Deductible: _____
Copay: _____

Dental No
Vision No

	First Name	Last Name	Relation (ee, sp, ch)*	Date of Birth	Gender	State	Zip Code	Enrolling in Coverage?	Reason for waiver of Medical
1									
2									
3									
4									
5									
6									
7									
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18									
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20									
21									
22									
23									
24									
25									

*ee = employee, sp = spouse, ch = child