

Client Name/Agency:	Telephone #:				
Address (including City, State and Zip Code):					

GROUP HEALTH INSURANCE COVERAGE

Employee Name	Gender	Date of Birth	Date of Spouse Birth/Age	No. of Children	Type of Coverage EE ES EC F			Plan Type		LTD or STD		Date of Hire	
					EE	ES	EC	F	НМО	PPO	Salary	Job Title	