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S S S S S S S S S S	15 Employee Required Contribution (see instructions)																		
Tetrill Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN or other TIN or exchange in the information for each individual enrolled in coverage, including the employee. (c) DOB (If SSN or other TIN or exchange in the information for each individual enrolled in coverage, including the employee. (e) Months of Coverage (e) Months of Coverage (e) Months of Coverage (f) May June July Aug Sept Oct Nov Dec (f) SSN or other TIN or exchange in the information for each individual enrolled in coverage, including the employee. (e) Months of Coverage (f) May June July Aug Sept Oct Nov Dec (f) SSN or other TIN or exchange in the information for each individual enrolled in coverage, including the employee.		\$	\$	\$	\$	\$	\$	\$	\$		\$		\$		S	\$)	\$	
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