GROUP INFORMATION

Company Name: _____

Group SIC Code: _____

Address: _____

Contact Person Name: _____

Phone Number: _____

Email: _____

Original Effective Date:

# of Eligible Employees: _____

# of Enroll Employees: _____ **# of Members:** _____

Current Carrier:

Current Plan :

Current Premium :

Note:

Required Fields in Orange Lettering										
Employee ID / #	Last Name	First Name	Date of Birth	Age	Gender (M,F)	Zipcode	Medical Status (EE,ES,EC or EF) for EE (SP or CH) for Dependents	Vision Status (EE,ES,EC,EMC or EF)	Dental Status (EE,ES,EC, EMC or EF)	COBRA (Y/N) Employee Only
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

Remark: