

PLEASE COMPLETE ENTIRELY FOR ALL FULL TIME EMPLOYEES TO UPDATE OUR RECORDS

GROUP NAME:	
Business Address:	
Group County Location:	
TYPE of Business:	

Employee Probationary Period for Insurance Eligibility:

	LAST NAME	FIRST NAME	DATE OF BIRTH	COUNTY OF RESIDENCE	SEX	DATE OF HIRE	GROUP HEALTH
ex	<i>Doe</i>	<i>John</i>	<i>12/12/1976</i>	<i>Okaloosa</i>	<i>M</i>	<i>12-Dec-96</i>	<i>FAM</i>
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Election of Coverage: **EE** = Employee ONLY **LO** = Life Only
ES = Employee AND Spouse **WP** = Waiting Period
EC = Employee AND Child(ren) ONLY **DECLINE** = Does not want insurance
FAM = Employee AND Spouse AND Child(ren)
WAIVER= Covered Elsewhere (on another insurance plan)