



Group Name: _____

Group Number: _____

IMPORTANT NOTE: This form must be accompanied by your State Quarterly Wage & Tax Report (or applicable tax documentation based on type of business arrangement noted below).

Please check the type of business arrangement: Sole Proprietorship Partnership Corporation
 S-Corporation LLC Other _____

EMPLOYEE CENSUS

List ALL employees in your firm including owners, partners, and managers, whether enrolled for coverage or not. (Attach a second page if necessary.)

	NAME	HIRE DATE MM/YYYY	HOURS WORKED PER WEEK	STATUS*	JOB TITLE	WAIVING YES/NO	WAIVER REASON**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

*** STATUS (key)**

F = Full-time	R = Retired	PP = Passive Partner/Owner
P = Part-time	C = Continuation (State/Federal)	WP = Within Waiting/Affiliation Period
T = Temporary or Seasonal	D = Totally Disabled Employee	O = Other (Please Explain)
I = Independent Contractor	A = Active Partner/Owner	

**** WAIVER REASON (key)**

SEP = Spouse's employer plan	MDC = Medicare/Medicaid	TRC = TRICARE (military)
CBR = COBRA	IM = Individual plan	OT = Other (Please Explain)

The employer currently contributes ____% (enter a percentage) toward eligible full-time employee medical premium. (Contribution information is not required in the state of Michigan.)

The employer agrees that all the information shown above is correct and complete.

Employee Name & Title _____ Date _____

Authorized Signature _____

Business Telephone No. _____ Fax No. _____

Business email address. _____

This form is being used as part of our internal administrative process to verify eligibility and participation requirements. Therefore, it is imperative that the information submitted is complete. It will not be used to verify health status of any individual employee.