



CENSUS FORM

BUSINESS NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please list all employees working 17.5 or more hours per week. Include employees: on medical COBRA or State Continuation, declining coverage and currently serving their probationary period.

**New Groups Only:** Please include waiver form at enrollment or reason for ineligibility for employees and/or their dependents declining coverage.

The employer may determine eligibility for their employees based on a threshold of between 17.5 and 40 hours per week. Please indicate the weekly eligibility hours the employer will be basing insurance eligibility on for this group. (Check one.)

17.5 hours     20 hours     30 hours     40 hours     Other \_\_\_\_\_

**DEPENDENT ENROLLMENT** - Please use the following codes for enrolling:

1 = Employee only    2 = Employee & Spouse    3 = Family    4 = Employee & Child(ren)

D = Declining Coverage Due to Other Group Coverage    NE = Not Eligible

#	Employee Name	Birthdate (6 digits)	Gender (M/F)	Date of Hire	Hours Working Per Week	Spouse (Y or N)	Total # of Dep.	Enrollment Code (see above codes)
	Suzy Sample	040374	F	010403	17.5	Y	1	3
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