

NEW GROUPS 2-50

EMPLOYEE CENSUS FOR MEDICAL OR DENTAL COVERAGE

Group Name:					EO: Emp Only ES: Emp + Spouse EC: Emp + Children EF: Emp + Family				
Address:									
#	SEX (M,F)	DOB or AGE	Type (EO, ES, EC or EF)	Out-of-Area Bus. Zip Code if applicable	#	SEX (M,F)	DOB or AGE	Type (EO, ES, EC or EF)	Out-of-Area Bus. Zip Code if applicable
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