Employee Census Form

EMPLOYEE NAME	ZIP CODE	GENDER M/F	DATE OF BIRTH	AGE	COVERAGE TYPE*	# OF CHILDREN	DENTAL	STD	LTD	LIFE

* Coverage Type:

Employee only = **E**
Employee & spouse = **ES**
Employee & child(ren) = **EC**
Employee & family = **EF**

List above all eligible employees interested in participating in group health plan.