CENSUS FOR OREGON BASED GROUPS

Name of Group:

Address:

City: **State:** **Zip Code:**

Effective Date:

Contribution & Eligibility

Minimum Hours	Minimum Days	Employer Contribution
		Employees:
Min. Employer Contribution = 50% EE, 0% DEP		**Dependents:**

Please provide information for **all** employees on payroll and their enrolling dependents below. Please use the following codes to show how each employee will or will not enroll in the medical/dental plan. Please number only the employees.

Enrollment Code Key:

EE (Employee Only)
ES (Employee+Spouse)
EF (Employee+Family)
EC (Employee+Child or Children)

WAIVE (Other qualified group coverage; I.E. Spouse's employer, OHP, Medicare, VA, etc.)
NE (Does not meet hourly requirement; Seasonal/Temp.)
OPT-OUT (Eligible Employee without other qualified coverage)

#	Employee Name	Gender M/F	Date of Birth	Enrollment Code		FT/PT	Date of Hire	Tobacco Use Yes/No	Zip Code
				MED	DEN				
1.	***Example:*** Doe, John	M	1/1/1970	EF	EF	FT	1/1/1990	No	97420
	Spouse - Jane	F	1/1/1972					Yes	
	Child - John Jr.	M	1/1/1995					No	
2.	***Example:*** Apple, Bob	M	1/1/1975	NE	NE	PT	1/1/1992	Yes	97459

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