Company (Group) Name_____ Phone No._____

Address_____ City_____ Zip Code_____

County_____ Cal COBRA Participants: Y/N How Many?_____ Multiple Locations: Y/N

CURRENT GROUP MEDICAL PLAN: Carrier_____ Plan_____

Contact Person_____ No. of EE's_____ Eff. Date_____

Please Print, Fill in, and Fax to:

(916) 635-0346

#	Employee Name	DOB	Sex	Status	Coverage Type	DOH	Zip Code	Job Title
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