Group Roster

Group Name ______________________ Date ___/___/___

Address ______________________

City __________ State __________ Zip __________

Phone __________ Fax __________ Email __________

How many employees (Including partners, shareholders) do you have? __________

Of this number, how many are part time? __________ How many have coverage through their spouse? __________

How many employees are waiving coverage? __________

Do you currently offer Blue Cross? ☐ yes ☐ no Association affiliation? __________

Please list all employees and owners on your payroll:

Name	Date of Birth	Employee Status*	Average # of Hours Worked per Week

Note: If more space is needed please use an additional sheet of paper

*Please indicate if (single, two person, family; including ages of children or Medicare)

1-800-632-4591
(616) 454-8257
Fax: (616) 454-6549