BRS Financial®

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GROUP HEALTH PLAN INFORMATION SHEET

From:_____
(Company Name)

Contact Person:_____

Address:_____

Phone:_____ Fax:_____

_____

Email:_____

Employee*	Occupation*	Date of Birth*	Sex	Marital Status* (S/C/F)	Monthly Income*	Health Coverage (S/C/F/N)	Dental Coverage (S/C/F/N)	Employee Start Date

***Required Fields**
S=Single **C**=Couple(Single Parent/Two Adults) **F**=Family **N**=No Coverage Required(only if coverage available under a spouse's plan)