

Company Name _____ Current payroll date (mm/dd/yy) _____

Using your payroll records, list all employees (including full-time, part-time, owners, and those waiving coverage). This form may be copied if additional space is needed, however, original signatures must be secured.

Please print or type. All information columns are required.

Employees are considered full-time if they work a minimum of _____ hours per week.

	Full name of employee	Date of birth	Age	Title or job description	Average number of hours worked
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

I certify that this information is complete and accurate. Care Choices HMO reserves the right to request payroll records to verify this information.

Employer Authorized Signature

Date