FORM 200

GENERAL NOTICES TO COMPANY

TO: Via Fax (724) 514-6648
Via E-Mail
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Human Resources America, Inc.
P.O. Box 8
Houston, PA 15342
724-514-6671

FROM: _____ ("Client") DATE: _____

_____ Contact name

_____ Contact Telephone

EMPLOYEE ELIGIBLE FOR COVERAGE

Name of Employee: _____ Date of Birth_____

Social Security Number_____ Employee's Hire Date: _____ Gender _____

Address: _____

_____

_____

Plan names or # _____Tier(Single, Emp. & Spouse, etc.)_____
Dental Plan _____Tier(Single, Emp. & Spouse, etc.)_____
Vision Plan _____Tier(Single, Emp. & Spouse, etc.)_____

Name of Spouse: _____ Date of Birth_____ SS #_____

Dependent Name: _____Date of Birth_____ SS #_____

_____Date of Birth_____ SS #_____

_____Date of Birth_____ SS #_____

_____Date of Birth_____ SS #_____

Date that Employee becomes Covered under the Plan: _____

Date that Spouse becomes Covered under the Plan (if different than Employee): _____

Date that Dependent(s) become(s) Covered under the Plan (if different than Employee): _____