



Fax: (920) 720-1256 Or mail to:
Attn: Sales Dept.
Network Health Plan
1570 Midway Place
Menasha, WI 54952

EMPLOYER DATA FORM

- 1. Requested Effective Date
2. Agency Name
3. Agent
4. Agency Contact Person's email
5. Corporate Name of Employer
6. Employer's Zip code
7. Company Contact's Name
8. Phone #:
9. List the names of any owners, officers or partners who are not covered by Worker's Compensation, and need on-the-job medical coverage with NHP

Employees must apply within thirty-one (31) days of becoming eligible or they will be considered a late applicant.

- 1. Employee waiting period: [ ] None [ ] 30 days [ ] 60 days [ ] 90 days [ ] 120 days [ ] 180 days
2. Do you want new employees currently in their waiting period to be eligible as of the group's plan effective date? [ ] Yes [ ] No
3. Are any employees or dependents totally disabled, confined to a nursing facility, or hospitalized at the current time? [ ] Yes [ ] No

If Yes, give names, ages, and date of disability:

Two horizontal lines for providing names, ages, and dates of disability.

Requested Benefit Plan: \_\_\_\_\_