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

EMPLOYER DATA FORM

1. Requested Effective Date _____
2. Agency Name _____
3. Agent _____
4. Agency Contact's Email _____
5. Corporate Name of Employer _____
6. Employer's Zip Code _____
7. Company Contact's Name _____
8. Phone Number _____
9. List the names of any owners, officers or partners who are not covered by workers' compensation and need on-the-job medical coverage with Network Health.

_____ _____

_____ _____

Employees must apply within 31 days of becoming eligible or they will be considered a late applicant.

1. Employee waiting period: ☐ None ☐ 30 days ☐ 60 days ☐ 90 days
2. Do you want new employees currently in their waiting period to be eligible as of the group plan's 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 dates of disability:

_____ _____

_____ _____

Requested Benefit Plan: _____