Employee information

Community Agencies Benefit Plans

Organization: _____ Date: _____

Employee name	Occupation	Workers' compensation coverage (Y/N)	Date employed (dd/mm/yyyy)	Single, Family, or Waiving* coverage status (S/F/W)	Date of birth (dd/mm/yyyy)	Sex (M/F)	Annual salary

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*Employees can waive Health and/or Dental coverage if covered through a spouses' plan.

Number of hours per standard work week per employee: _____ hours.

Are any employees currently off work due to a disability or workplace accident? If so, please provide an explanation:

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