WESTERN GROCERS EMPLOYEE BENEFITS TRUST

EMPLOYEE CENSUS FORM

PLEASE COMPLETE AND RETURN BY MAIL, FAX OR EMAIL

BUSINESS NAME _____ CONTACT PERSON _____ DATE _____/_____/_____

MAILING ADDRESS _____ CITY _____ ST _____ ZIP _____ COUNTY_____

PHONE _____ FAX _____ EMAIL _____

Please list all eligible employees. For those enrolling, identify any dependents to be included. For eligible employees not enrolling, identify why in the waiver reason column.

Dependent Relationship:
C = Child
S = Spouse
D = Domestic Partner

Waiver Codes:
D = Declined
O = Other coverage
M = Medicare/Medicaid

EMPLOYEE NAME | If dependents are to be covered, list name(s) after employee and include Birth Date and Relationship	BIRTH DATE xx / xx / xxxx	DEPENDENT RELATIONSHIP C / S / D	HOURS WORKED PER WEEK	EMPLOYEE ENROLLING Y or N	If NO – Waiver Reason Code D / O / M

Note: Copy this page to list additional employees or provide us the information on your own form if you prefer.

Western Grocers Trust ▪ PO Box 22166 Portland, OR 97269
Fax: 503.968.2817 ▪ E: tomn@westerngrocerstrust.com