Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
24						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐