Department of Employee Trust Funds
801 W. Badger Road
P.O. Box 7931
Madison, Wisconsin 53707-7931

GROUP HEALTH INSURANCE
MONTHLY ADDITIONS REPORT

Wis. Stat. § 40.06

Employer Name	Employer Number	Group #	Carrier Suffix	Deduction Month	Coverage Month
	69-036-				

Enrollment Type/Code	Employee Type/Code	EMPLOYEE Name Last, First, Middle I.	EMPLOYEE Social Security No.	Date of Hire or Re-hire	If changing carrier, provide previous carrier suffix	Effective Date	Contract Type Single	Contract Type Family	PREMIUM ADJUSTMENT PREVIOUS MONTH(S) (List individual months) Month	PREMIUM ADJUSTMENT PREVIOUS MONTH(S) (List individual months) Amount
TOTAL ADDITION IN CONTRACTS			Post to Line 2 of the Monthly Coverage Report:							

See your Health Insurance Administration Manual for detailed instructions.