


# Initial Electronic Enrollments Employer Guide



Please use the table on the back of this page as a guide to filling out the *Initial\_Electronic\_Enrollments\_Format.xlsx* spreadsheet. Completing the information in this format will ensure that your employees' data is quickly and accurately uploaded into Security Health Plan's system. If you have questions about how to fill out the spreadsheet, please contact your sales account executive or account manager.

**SecurityHealth Plan**<sup>SM</sup>  
Promises kept, plain and simple.<sup>®</sup>

Column	Field name	Description	Status	Format	Example
A	Family ID	Ignore for medical enrollments. Required for wellness ONLY enrollments	See description notes	Numeric	1, 1, 2, 3, 4, 5, etc.
B	Employee/Subscriber SSN	Social Security number (SSN) of the employee/subscriber	Required	Do NOT include dashes	123456789
C	Individual Last Name		Required		Smith
D	Individual First Name		Required		John
E	Individual's Middle Initial/Name		Optional		Paul
F	Individual Suffix	JR, SR, III, IV, V (if applicable)	Optional	Uppercase with no punctuation	JR
G	Individual DOB	Date of birth	Required	MM/DD/YYYY	10/18/1965
H	Individual Relation	Employee, Spouse, Child, Grandchild, or Domestic Partner * Select "Employee" if the individual is also the subscriber	Required		Employee
I	Individual Gender	M or F * Select the gender the individual identifies with	Required		M
J	Individual SSN	Social Security (SSN) number of the individual * Required for individuals with a relationship of subscriber, spouse, child, grandchild or domestic partner age 18 and over * Optional for individuals age 17 and under with a relationship of spouse, child, grandchild or domestic partner	See description notes	Do NOT include dashes	123456789
K	Email Address		Optional		johnsmith@gmail.com
L	Marital Status	Single, Married, Divorced, Widowed, Unknown	Optional		Married
M	Individual Physical Address 1	Street address	Required		123 Main Street
N	Individual Physical Address 2	Apartment, suite, unit or other additional information	Optional		Apartment 5
O	Individual Physical Zip		Required	5 digits only (do not include the plus-4 suffix)	54449
P	Individual Physical City		Required		Marshfield
Q	Individual Physical State		Required		WI
R	Individual Physical Country		Required		United States
S	Mailing Same As Physical?	Yes/No * If "No", mailing address information in Columns T-Y is required	Required		Yes
T	Individual Mailing Address 1		See description notes in Column S		
U	Individual Mailing Address 2		See description notes in Column S		
V	Individual Mailing Zip		See description notes in Column S		
W	Individual Mailing City		See description notes in Column S		
X	Individual Mailing State		See description notes in Column S		
Y	Individual Mailing County		See description notes in Column S		
Z	Individual Home Phone		Optional	Include dashes	555-555-5555
AA	Effective Date	Effective date of the enrollment being added	Required	MM/DD/YYYY	01/01/2017
AB	Group Number	Enrollment group number	Required		778899
AC	Hire Date		Optional	MM/DD/YYYY	05/05/2014
AD	Is Individual a Retiree?	Yes/No	Required		No
AE	Is Individual on COBRA?	Yes/No	Required		No
AF	Is Dependent Out Of Area?	Yes/No * Dependent out-of-network coverage is based on an employer's benefit structure. If you have further questions about this, please contact your sales account executive or account manager.	Required		No
AG	Main Coverage Code ID		Leave blank for Security Health Plan use		
AH	Subgroup		Leave blank for Security Health Plan use		
AI	PCP First Name		Optional		Ramon
AJ	PCP Last Name		Optional	Do NOT include MD, PA, etc.	Espada
AK	Facility Healthcare is Received From	Name of clinic or other entity that primary care is received from	Optional		Marshfield Clinic