DRUG PLAN / INFORMATION SHEET

Company: _____ ☐ Operator ☐ Contractor ☐ Other: _____

Administrator of Drug Plan:

Name: _____ Title: _____

Alternate Administrator: *(if needed)*

Name: _____ Title: _____

COVERED EMPLOYEE'S DATA

Name	Title	If supervised date of training	Date of coverage started	Date removed from coverage	Operator's employee	If no, name of contractor
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	