Signature of Authorized Officer, Partner or Proprietor:_____ Date: _____

Employers Group Trust

Group Name:

	Name		DOB	Gender	Date of Hire Mo Day Yr		State &	Annual	Coverage	Beneficiary
Social Security #	Last	First & MI	Mo day Yr	M/F	(30 Hr Min.)	Occupation	Zip	Salary	Code*	Code**

*Coverage Code:
L= Life
S= STD
D= Disability (LTD)
DL= Dep. Life

**Beneficiary Code:
1= Spouse
2= Child(ren)
3= Parent(s)
4= Estate
5= No Relatiopnship