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

Employers Group Trust

Group Name:

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

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

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