EMPLOYEE GROUP BENEFIT
CENSUS DATA FORM

COMPANY NAME: ____________________ **TODAYS DATE:** ____________________

	EMPLOYEE NAME	M/F	DOB	JOB TITLE	*MONTHLY EARNINGS	(ENROLLMENT STATUS) S	M	CHILD
1								
2								
3								
4								
5								
6								
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8								
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11								
12								
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24								
25								

***Please ONLY complete monthly earnings column if you are requesting a disability income quote.**

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