NAME OF YOUR COMPANY________________________________

Fax to :(954)-975-3484
Email to:InsuranceDepot@aol.com

CONTACT PERSON'S NAME :___________________________

PHONE NO# HERE: (________)-______________________

EMPLOYEE STATUS	
EMPLOYEE ONLY	EE
EMPLOYEE & SPOUSE	ES
EMPLOYEE & CHILDREN	EC
FAMILY	F

FULL TIME (25 HRS WEEKLY) EMPLOYEE NAME	SEX M or F	AGE	DATE OF BIRTH		EMPLOYEE STATUS	EMPLOYEE SALARY ***	EMPLOYEE OCCUPATION ***
				1			
				2			
				3			
				4			
				5			
				6			
				7			
				8			
				9			
				10			
				11			
				12			
				13			
				14			
				15			
				16			
				17			
				18			
				19			
				20			

IF YOU HAVE MORE THAN 20 EMPLOYEES PLEASE PRINT ADDITIONAL PAGES

____

YOUR COMPANY ADDRESS

____

CURRENT INSURANCE CARRIER

CITY________________STATE________ZIP_________

Questions? Call 800-934-0244

EMAIL:____________________ FAX:______________________

*	ASSUMES 75% OF ALL ELIGIBLE EMPLOYEES APPEARING ON THE UCT QUARTERLY WAGE & TAX
**	ASSUMES EMPLOYER IS PAYING MINIMUM OF 50% OF EMPLOYEE PREMIUM
***	SALARY & OCCUPATION REQUIRED IF REQUESTING DISABILITY INSURANCE