



Factfinder Group Long Term Disability

EMERGENCY SERVICE ORGANIZATION INFORMATION:

Name of Organization: _____

Name of Sponsor: _____

Mailing Address: _____

Street or PO Box City/Twp/Borough County State Zip Code

Physical Address: _____

Street City/Twp/Borough County State Zip Code

Telephone Number: () Fax Number: ()

E-Mail Address: _____

Type of organization: Ambulance County Fire Department Relief Assoc. Rescue Squad
(Please check one)

CONTACT INFORMATION FOR EMERGENCY SERVICE ORGANIZATION:

Name: _____ Title: _____

Telephone Number: () Work Home E-mail Address: _____

PRODUCER INFORMATION:

Name of Producer: _____

Producing Agency: _____

Address: _____

Street or PO Box City/Twp/Borough State Zip Code

Telephone Number: () Fax Number: ()

E-mail Address: _____

Are you a life licensed? Yes No

DATA REQUIRED FOR A GROUP LONG TERM DISABILITY PROPOSAL:

Census data including: Member's name, date of birth and annual salary

***Please review census to ensure legibility.**

Proposed Effective Date of the Plan: _____

Please contact the Benefits Division for information on transferring your census data electronically.