Firm Name:					
Address:					
City:		**State:**		**Phone:**	
Zip:		**County:**		**Fax:**	
Tax ID:					
Requested Effective Date:					
Total # of Eligible Employees: (Anyone working 25 hrs or more)					
Total # of Employess Participating:					
Current Carrier					

OHIO STATE BAR ASSOCIATION
INSURANCE AGENCY, INC.

Notes:

Employee Name	Date of Birth	Last 4 Digits of Socials Employees Only	Gender	Tobacco Use	Zip Code	County	Employee/Dependent Indicator	Medical	Dental	Vision	Disability	Life	Salary if interested in Disability	Number of Hrs worked per week