Principal Life Insurance Company
Census Form

Company:_____

Date:_____

Required	

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	DATE OF BIRTH MM/DD/YYYY	GENDER M or F	CURRENT SALARY	OCCUPATION Please provide job title for each employee For physicians, enter physician type *(e.g. dermatologist, pediatrician, etc)*	DENTAL / VOL DENTAL E = Employee ES = EE/Spouse ESC = Family EC = EE/Child Please input one option or leave blank if Employee is waiving benefit	VISION / VOL VISION E = Employee ES = EE/Spouse ESC = Family EC = EE/Child Please input one option or leave blank if Employee is waiving benefit

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