O R D E R F O R M

***REQUEST FOR DISABILITY PREMIUM WAIVER* (ET-5306)**

DEPARTMENT OF EMPLOYE TRUST FUNDS
PO BOX 7931
MADISON WI 53707-7931

Request for Disability Premium Waiver (ET-5306) # Forms _____

Employer Name_____ EIN 69-036-_____

Your Name _____ Title _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____