# **PHP** Insurance Company

## **New Group Checklist**

## 30 days prior to the effective date, the following Group information is required:

- Group Policy Application completed and signed.
- Enrollment forms; be sure to complete any applicable COB information.
  - Include waivers for all eligible employees
- MESC/Quarterly Wage Detail Report (most current) if enrollee is **NOT** on wage detail please provide <u>proper tax returns</u> &/or copy of W4 and most recent pay stub.
  - S Corporation
    - ✓ IRS Form 1120S (U.S. Income Tax Return for an "S" Corporation) and Schedule K-1 (Shareholders Share of Income, Credits, Deductions, etc.)
  - Partnership/LLC -
    - ✓ IRS Form 1065 (U.S. Partnership Return of Income) and Schedule K-1 (Shareholders Share of Income, Credits, Deductions, etc.). A Partnership Agreement is also acceptable with all partners names listed.
  - Sole Proprietorship
    - ✓ Schedule C from proprietor's IRS form 1040
- Previous detailed carrier bill. (if not applicable will NEED tax returns)
- HRA/HSA/FSA Attestation
- New Business Eligibility Verification Form
- Group Pediatric Dental Attestation form small group only

When completing forms:

- Each Enrollment Form requires both employee and group contact signatures.
- Social Security numbers are required for all.
- Street address is required if employee uses a POB for mailing address.
- Please write legibly.

### After PHP receives the initial materials above:

- The Final Rates page will be developed using the census information gathered from the member enrollment forms.
  - Once generated, PHP will send the Final Rates page back to the group contact/agent.
  - When signed by the agent or group contact it is to be sent back to PHP.
  - After the final rates are signed, the group will send a binder check to PHP for the first month of premium.
- Verify if employee packets or open enrollment meetings are required.
- Member ID cards.
  - It takes approximately three days for members to be enrolled in PHP's system.
  - Cards will be sent to the member's homes approximately 10 days after being entered into the system.

## Physicians Health Plan

# **PHP** Insurance Company

## SMALL GROUP POLICY APPLICATION

HMO EXC \_\_\_\_ POS \_\_\_\_ PPO \_\_\_\_

( initital please )

Company name to be listed on Policy			Effectiv	e Date of Covera	ge		
Contact Person		Employer Taxpayer ID #					
		SIC Code					
Street Address							
City State	Zip	Mailing Add	dess (if different from S	Street Address)			
ony orace	Σip			nieer Address)			
County:							
Phone Fax							
		City		State	Zip		
MANDATORY Email address:							
Billing Contact Person (if different from a	above)		Eligibility	/Participation			
		How many	total employees do you	u have			
Street Address		(including t	hose who may not be e	eligible for covera	ge)		
City State	Zip	Total numb	er of enrollees				
Unity Unite	Σip	Total numb	er of waivers	+			
Phone Fax		Total numb	er of eligible employee	es =			
( ) ( )		Com	pany Legal Status; (i	i.e. S Corp. LLC. P	Partnership, etc)		
Premium Contributio	n		,, <u></u>				
Indicate the % of premium, or the dollar	amount, the		Unior	n Contract			
employer contributes toward employee	Are any em	ployees covered by a	union contract?				
%		Local #	C	ontract Exp. Date			
Is the group currently a member of a sp	onsored association or	chamber?					
If yes, please indicate name of associati	on or chamber:						
	Previous	insurance co	verage				
Did your company have previous health	insurance coverage?		Yes	No			
If yes, please indicate the name of the p	revious carrier						
Is your current plan grandfathered unde	r Health Care Reform?		Yes	No			
Dependent Age 26 Coverage T	ermination	DED	<b>UCTIBLE ROLLOVER</b>	R from PRIOR C	ARRIER		
End of Calendar Month:	-	YES		NO			
End of Calendar Year:			ave information 21	days after effe	ctive date		
Medical Benefit:	Rx Benefit:	nefit Selectio	n Delta Dental:				
ואכעולמו שבוופוונ.				Yes	No		

## Physicians Health Plan

# **PHP** Insurance Company

Enrollmen	t/Eligibility Criteria					
Eligible for coverage: ACTIVE:Employee working a minimum of Other:	Temporary Seasonal					
RETIREES: (not to exceed 10% of the active enrolled	d population)					
Effective Date for New Hires:	Effective Date for Return to Employment:					
(NOT to exceed 91 days from date of hire)	(NOT to exceed 91 days from date of return)					
Date of Hire	Date of Return					
First of the month following day waiting period	First of the month following day waiting period					
Date of completion of day waiting period.	Date of completion of day waiting period.					
Effective Date for Status Change:	Effective Date for Termination of employment:					
(NOT to exceed 91 days from date of change)						
Date of Change	Date of termination of employment					
First of the month following day waiting period	Last day of the month in which termination occurs					
Date of completion of day waiting period.						
contemporaneous negotiations, representations, or agreements (whether written or oral) between the parties. PHP may, at its discretion, request supplemental information from any individual or company, including but not limited to information service agencies, medical or credit information bureaus. The Enrolling Group certifies that the information contained in this application is accurate and agrees that issuance of coverage is based on this application, which shall become a part of the Policy. Any material omissions, misrepresentations or misstatements in the information requested on this form can result in voiding or reformation of insurance. By applying, the Enrolling Group agrees to all of the terms and conditions of this application, and all of the terms and provisions of the group insurance policy, as amended from time-to-time. Coverage will not become effective unless this application is accepted in writing by PHP.						
Name of Producer	Agency					
Printed Applicant Name	Applicant Signature					
Applicant Title	Date					
For Physicians Health Plan Use Only						
Group Number Sub Grp Number Polic	y Effective Date Sales Executive					
Class Description	Class Description					
Class Description	Class Description					
Binder Check Check Amount	Received					

# **PHP** Insurance Company

# **HRA/HSA/FSA ATTESTATION**

Plan ID(s): \_\_\_\_\_

PLAN EFFECTIVE DATE: \_\_\_\_\_

### **PURPOSE:**

The PHP Insurance Company coverage selected by the group is not attached to a Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). By signing below, you indicate that you understand and are not currently using or intend to use an HRA, HSA or FSA to fund your employees cost sharing responsibilities.

### PLAN SPONSOR INFORMATION & ATTESTATION:

Group Name

Employer(s) Federal Identification Number

I, the undersigned, duly-authorized representative for

("Name of Group"), understand that I have selected a plan without an HRA or FSA attached that is not HSA compatible. I hereby attest that I will not fund an HRA, HSA or FSA and employees will be fully financially responsible for all member cost-sharing. I also acknowledge that by signing this attestation, I understand that knowingly giving incorrect information is considered a breach of contract with PHP Insurance Company and in such case, is cause for termination of our Group Policy.

Group Representative Printed Name and Title

Signature

Date

**Producer Printed Name** 

Producer Signature

Send completed forms to: PHP Insurance Company PO Box 853936, Richardson, TX, 75085-3936 Or Fax to: (517) 364-8416 ATTN: Enrollment Department

**Enrollment Form** 



#### PLEASE PRINT LEGIBLY

Application for:       Medical       Delta Dental         Waiver of Coverage:       I decline coverage for:         Employee & all dependents       Spouse only         Reason:       Covered under another health plan         Other (specify):					dents only						
A. Employee & Family Information											
Employee's		First				Middle	;	Soc	ial Security	у	
Last Name		Name				Initial		Nur	nber		
Street		DO D		A ( NT		City			State	Zip	
Address Home	Work	PO Box	x Em	Apt. No	0.					Language	preference
Phone ( )	Phone	( )	Lin	an		@				Language	preference
Date	Gender	Ethnicity	Ma	rital Statu	is:	Single	_	Marr			Divorced
of Birth Independent Contract	tor?			Daimoar	Care Ph	Widowed	1	Separ	rated	Cum	rent Patient?
	No			Filliary	Cale Fli	ysiciali				Cui	Y / N
	Last Name/F								City/Phone		
Please list family me	embers to be cover	ed under this poli	cy. Please Social Se		lditional	form if need	ed. Write			<b>appear on I</b> re Physician	D Card. Current
First Name	M.I. L	ast Name	Numb		Relationshi	ip Gender	Date of E			ast Name	Patient?
1											Y / N
2											Y / N
3											Y / N
4											Y / N
											1,11
5											Y / N
B. Coordination of	f Benefits – (Fail	ure to comple	te this se	ction ma	ay resul	lt in delay	s in enro	ollment	or claim	payment	s)
On the day your cove	rage begins, will an	y family members	above be c	covered by	other me	dical, dental	or Medica	ire insuran	ice?		
Coverage type (please	e attach copy of oth	er medical insuran	ce card):	Name	of		1 1		Policy H	Holder	
Medical Insurance	e 🗌 Medicare	Dental Insu			Holder		D I' II	11 2	Date of	Birth	
Insurance Company Name & Phone Num	her		Polio Num				Policy Ho Employer				
Medicare		Medicare			edicare Pa	art B	1 2	are Part D	)	Medicare	Part C
Policy Number		Effective I			fective Da		Effecti	ive Date		Effective I	Date
Reason for Medicare:     End Stage Renal Disease     Please list everyone     Coverage       Disability     Down and (5 and marking)     Detection     Detection											
Disability       Over age 65       Over age 65 and working       covered by other insurance:       Dates:         C. Employee Signature – this form must be signed by the employee even if waiving coverage.       Dates:											
ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage. NOTICE OF ENROLLMENT RIGHTS: I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may be able to enroll myself and my dependents in this policy if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing towards my or my dependents' other coverage). However, I must request enrollment within 30 days after my or my dependents for adoption, I may be able to enroll myself and my dependent as a result of marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, I can contact PHP Customer Service at (517) 364-8500.											
Employee Signature Date Signed											
D. For Employer Use only – must be completed in order to process         Group       Group Number:       Sub Group       Class       Effective											
Name:		Group	Number:			ub Group Jumber		Number		Date:	e
Qualifying event date	Qualifying event re	Return 🗌 Status	Change		🗌 Par	ll Time rt Time		]Union ] Non Uni	ion	Sala	aried urly
Employer Representative Printed Name: Phone Number:											
Employer Representa											
For questions regarding this form, please e-mail – php.enrollment@phpmm.org or call the PHP Enrollment Department at (517) 364-8320											

**Change Form** 



Employee must sign this form for anything other than a termination of employment.

First Last Number / Date of   Number / / Date of   B. Employee Changes Birth / /   Change Adress to: : :   Change Mines to:: : :   Change M	Name       Name       Number       / <t< th=""><th colspan="6">A. Employee information (as it appears on ID Card)</th></t<>	A. Employee information (as it appears on ID Card)							
B. Employee Changes       Change Address to:         Change Address to:       Change American Form:       to:         C. Change In Coverage       Bith       Address to:         I. Additions:       Add Medical Coverage       Bith       Address to:         Add Medical Coverage       Bith       Address to:       Effective Date of Address to:         I. Additions:       Coverage   Address to:       Bith       Address to:       Effective Date of Address to:         Add Medical Coverage       Coverage Address to:       Description       For employee and all coverage   Other (specify):       Iffective Date of the Address to:         Changes:       Coverage Address to:       Description       Description       Iffective Date of change to:         Changes:       Changes:       Changes to: (OBHA coverage Change from Class:       To:       Effective Date of change to:       Iffective Date of change to:         Changes:       Changes:       Changes:       Changes:       Medical Borena coverage begins:       Iffective Date of change to:         Changes:       Iffective Date of change to:       Iffective Date of change to:       Iffective Date of change to:         Changes:       Iffective Date of change to:       Iffective Date of change to:       Iffective Date of change to:         Changes:       Iffective Date of change to:	B. Employee Changes					irity		1 1	
Change Address to:       to:         Change Mant from:       to:         Change In Coverage       Add Dental Coverage       Qualifying event reason:       Maringe       Meffective Date of Addition:         Addition:       Change in Coverage       Add Dental Coverage       Qualifying event reason:       Meffective Date of Addition:       ////////////////////////////////////	Change Address to:       to:         Change Name from:       to:         I Additions:       I Additions:         I Additions:       I Additions:         I Additions:       I Change in Coverage       Add Dental Coverage       I Change in Coverage       I C		Iname		Number	/ /	Birth	/ /	
Compage in Coverage     Add Dental     Add Dental Coverage     Add Dental Coverage     Add Dental	C Change in Coverage  Add Dental Coverage  Add Dental Coverage  Add Medical Coverage  Add Dental Coverage  Add Medical Coverage  Add Dental Coverage  Birth  Coverad Bern  Add Medical Coverage  Add Dental Coverage  Birth  Coverad Bern  Coverad  Covera								
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LAddifions:       Qualifying event reason:       Effective Date of Addifion:         Add Marking Coverage       Add Dental Coverage       District (Specify):       Image: Addifion:         Constraintions:       For employee and all coverage (Denter Cypecify):       Image: Coverage (Denter Cypecify):	Image:       Qualifying event reason:       Marriage       Marriage       Add Marcial Coverage       Image:       Add Marcial Coverage       Image:       Add Marriage       Addition:         2. Terminations:	Change Name nom.		10.					
Add Medical Coverage       Add Dental Coverage       Bith       Adoption       Marriage       ////////////////////////////////////	□ Add Medical Coverage       □ Add Dental Coverage       □ Adoption       □ Addrives       □ Adoption       □ Addrives       □ Addrives         2. Terminations:       □ For employee and all       □ For employee and all       □ Coveral dependents       □ For employee								
	Less of laber coverage      Other (specify):								ate of
2. Terminations:       For employee and all       Reason:       For employee and all       Reason:       For employee and all       For employee and all for employee and all for all	Image: <pre></pre>							Addition:	1
Bendal       Browne       Divorce       Dissatisfied       Other (specify):	Dental          B For dependents listed        Divorce        Dissatisfied         Other (specify):			eason:	•	,poenij):		Effective D	ate of
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3. Changes:       Reason       Effective Date of change         Image:       Image:       Image:       Image:         Please Bit family nembers to be added/decired under this policy. Please attach additional form if acceded. Write name as it should appear on ID Card. Dependent may not be eligible if other medical coverage is available to them through this employer.         Image:       Image: <t< td=""><td>a. Changes:       Reason       Effective Date of change         Image: Change to COBRA coverage       Class:       Reason       Effective Date of change         Press flat family members to be added/deled under this pails:       Plass stateh additional form if accided. Write name as it should appear on ID Card. Dependent may not be clighted if other medical coverage is available to them thread their employer.         Image: International coverage is available to them thread their employer.       Date of Birnh       Gender       Relationship       Medical Insurance available from his/her employer?         Image: International coverage begins.       Image in the coverage is available to them thread their employer.       Image in the coverage is available from his/her employer?         Image: International coverage begins.       Image in the coverage is available from his/her employer?       Image in the coverage is available from his/her employer?         Image: International coverage begins.       Image in the coverage begins.       Image in the coverage begins.       Image in the coverage begins.         Image: International coverage begins.       Image in the coverage begins.       Name of the coverage begins.       Policy Holder       Dolicy Holder         Image: International coverage begins.       Image international coverage begins.       Policy Holder       Dolicy Holder       Image international coverage begins.         Image: International coverage begins.       Image international coverage begins.</td><td></td><td>endents listed</td><td></td><td></td><td>Other (specify):</td><td></td><td>/</td><td>1</td></t<>	a. Changes:       Reason       Effective Date of change         Image: Change to COBRA coverage       Class:       Reason       Effective Date of change         Press flat family members to be added/deled under this pails:       Plass stateh additional form if accided. Write name as it should appear on ID Card. Dependent may not be clighted if other medical coverage is available to them thread their employer.         Image: International coverage is available to them thread their employer.       Date of Birnh       Gender       Relationship       Medical Insurance available from his/her employer?         Image: International coverage begins.       Image in the coverage is available to them thread their employer.       Image in the coverage is available from his/her employer?         Image: International coverage begins.       Image in the coverage is available from his/her employer?       Image in the coverage is available from his/her employer?         Image: International coverage begins.       Image in the coverage begins.       Image in the coverage begins.       Image in the coverage begins.         Image: International coverage begins.       Image in the coverage begins.       Name of the coverage begins.       Policy Holder       Dolicy Holder         Image: International coverage begins.       Image international coverage begins.       Policy Holder       Dolicy Holder       Image international coverage begins.         Image: International coverage begins.       Image international coverage begins.		endents listed			Other (specify):		/	1
Integriting the strength of and ender the policy. Please attach additional form if necked. Write name as it should appear on D Card. Dependent may             muther if in the medical coverage is available to them through their employer.          Image of the integriting of a data of the medical coverage is available to them through their employer.        Date of the ender the integriting of the medical coverage is available from             his/her employer?          Image of the integriting of the medical coverage is available to them through their employer.        Date of the ender the integriting of the in	These lish finally members to be added/deled under this policy. Please attach additional form if needed. Write name as it should appear on ID Card. Dependent may not be eligible for them remoted to them through their employer.         In the eligible if other medical coverage is available to them through their employer.       Date of first Name       Medical Insurance available from his/her employer?         Image: Image is the instruction of the instruction	3. Changes:			Reason	n	Effec	tive Date of c	hange
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Delete       / / / / / / / / / / / / / / / / / / /	Delete       /       /       /       /       /       /         Delete       /       /       /       /       /       /       /         D. Coordination of Benefits (Failure to complete this section may result in delays in enrollment or claim payments)       On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance?       On the day your coverage togs:       On the day your coverage togs:       On the day your coverage togs:       Date of Birth / /       /         On the day your coverage togs:       On the day your coverage togs:       Name of Policy Holder       Date of Birth / /       Date of Birth / /         Nome & Phone number       Name of Policy Holder's       Date of Birth / /       Date of Birth / /       /         Name & Phone number       Number       Employer       Medicare Part A       Effective date //       /       /       /         Policy Number       Please list everyone coverage by other insurance       Coverage       Date of I / /       /	_							
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D. Coordination of Benefits (Failure to complete this section may result in delays in enrollment or claim payments)         On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance?         D. More UYes If yes, please complete this section and attach a copy of the card. Please use extra paper if more than one additional policy will be in force.         Coverage type:       Dental Insurance       Medicare         Policy Holder       Date of Birth / /         Mame & Phone number       Number       Policy Holder's         Mame & Phone number       Number       Employer         Medicare regions for Medicare in the form must be signed by other insurance       Coverage Dates / /       Medicare Part A         Policy Number       Please list everyone covered by other insurance       Coverage Date       Medicare Part C         Medicare Part G       Over age 65       Over age 65 and working       Effective Date       Effective Date       Iffective Date	Delete       / / / / / / /         D. Coordination of Benefits (Failure to complete this section may result in delays in enrollment or claim payments)         On the day your coverage begins, will any family members above be covered by other medical, dental or Medicare insurance?         No       Vest If yes, please complete this section and attach a copy of the card. Please use extra paper if more than one additional policy will be in force.         Coverage type:       Name of         Policy Holder       Date of Birth / /         Insurance Company       Pelase list everyone covered by other insurance       Policy Holder's Employer         Medicare Part A       Policy Number       Medicare Part A         Policy Number       Please list everyone covered by the employee torm at the intervence of the card. Please and anyone emoleto are addition or the card of the care Part C       Medicare Part A         Policy Number       Please fist of the care Part B       Medicare Part C       Medicare Part D         Disability       Over age 65       Over age 05 und working       Iffective Date       Iffective Date <td>_</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	_							
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* By checking this box, I certify that the affected individual was notified of the loss of coverage prior to the termination date.		$\square$ * By checking this box. I certify that the	ne affected individual w	as notified of the lo	ss of coverage pr	ior to the termination	on date.		
	Tor questions regarding this form, prease e-main				<u> </u>				

# **O** Physicians Health Plan

#### **GROUP PEDIATRIC DENTAL COVERAGE ATTESTATION**

The Physicians Health Plan or PHP Insurance Company group health benefit plan that you wish to purchase does not include pediatric dental coverage. Because of this, federal and state law provide that you are only eligible to purchase this group health benefit plan if you also purchase group pediatric dental coverage offered by an Exchange-certified standalone dental plan. PHP can assist you in obtaining group pediatric dental coverage offered by an Exchange-certified standalone dental plan.

Because you are only eligible to purchase this group health benefit plan if you also purchase group pediatric dental coverage from an Exchange-certified standalone dental plan, PHP is required to obtain reasonable assurances from you that you have such coverage before PHP is permitted to sell you this group health benefit plan. Therefore, please attest to the following:

- I understand that I am only eligible to purchase this PHP group health benefit plan if I also purchase group pediatric dental coverage offered by an Exchange-certified standalone dental plan.
- I certify that I have purchased group pediatric dental coverage offered by an Exchange-certified standalone dental plan.
- I will inform PHP immediately if this group pediatric dental coverage is discontinued for any reason.
- I understand that if I am not truthful in this attestation, the PHP group health benefit plan may be rescinded by PHP due to fraud or intentional misrepresentation of material fact, and that the group may be required to reimburse PHP for any medical expenses that PHP paid on its behalf.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_\_

Group Name: \_\_\_\_\_\_

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A Sparrow Subsidiary

1400 E. Michigan Avenue P.O. Box 30377 Lansing, Michigan 48909-7877

T 517.364.8400 F 517.364.8460 phpmichigan.com

#### DISABLED DEPENDENT VERIFICATION FORM

#### **Physician Certification**

This form is used to certify physical or mental disability of a member for purposes of continued coverage with PHP. This form must be completed and signed by the member's treating physician. PHP reserves the right to request this certification on an annual basis.

#### Please Print: Patient/Member Full Name:

Date of Birth:

F

Diagnosis:	Date of Diagnosis:
Is This Considered – Permanent 🛛 Temporary 🛛	

Anticipated Course and/or Duration of Disability:

Describe the nature of the disability that results in the patient/member being incapable of self-support: (Functional limitations, i.e., self care, understanding and use of language, learning, mobility, self direction, and capacity for independent living. Attributable to mental retardation such that the person has significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period; cerebral palsy, epilepsy, autism; or any retardation because this condition results in impairment in general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons. Please provide evidence of the individual's deficits in intellectual functioning or adaptive behavior.)

Physician's Name (please print):

Physician's Signature:

Date:



## **New Business Eligibility Verification Form**

#### GROUP NAME: \_\_\_\_\_

Physicians Health Plan must obtain from a prospective employer group the number of eligible employees within each organization to ensure proper rating of the group.

Two key definitions that will be helpful in completing this form:

- 1. An *employer group* includes all offices, locations, or branches, whether or not employees at those sites are included under your healthcare contract with PHP.
- 2. An eligible employee includes an employee who works on a full-time basis with a normal workweek of 30 or more hours and may include those employees who work on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all employees and without regard to health status related factors. Do not include Retirees and COBRA participants in your eligible employee count.

Total number of employees entered on your Quarterly Wage Detail (IRS Form 941, Part 1, Line 1) – please include owners	
Total number of eligible employees	
Total number of employees NOT eligible for company sponsored healthcare coverage	
Total number of eligible employees declining coverage	
Does your company offer coverage with any other carrier? (Yes/No)	
If "Yes", please provide:	
# of eligible employees covered under other healthcare plan(s)	
The carrier(s) name	
Does your company offer retiree coverage? (Yes/No)	
If "Yes", please provide:	
# of retirees covered under company sponsored retiree healthcare plan(s)	
The carrier(s) name	

Authorized Group Representative Signature

Printed Name

Title

Date

If you have questions regarding this form, please call your Account Executive at (517) 364-8484.