

New Benefits/New Carrier Change Form



1. Employer Information

Company Name

Administrative Contact

Phone

2. Carrier Information

Please complete only the applicable section(s) where a benefit has been added or a carrier has changed.

Health Carrier

Group Number

Administrative Contact

Phone

Fax

Address

City

State

ZIP

Monthly Premiums \$ Single \$ Two Party \$ SPD \$ Family

*If self-insured, please attach the suggested funding level or rate sheet used.

Dental Carrier

Group Number

Administrative Contact

Phone

Fax

Address

City

State

ZIP

Monthly Premiums \$ Single \$ Two Party \$ SPD \$ Family

*If self-insured, please attach the suggested funding level or rate sheet used.

Vision Carrier

Group Number

Administrative Contact

Phone

Fax

Address

City

State

ZIP

Monthly Premiums \$ Single \$ Two Party \$ SPD \$ Family

*If self-insured, please attach the suggested funding level or rate sheet used.

Section 125 Administrator

Maximum Medical Spending Account Plan Year Election

Administrative Contact

Phone

Fax

3. Authorized Signature

Employer Representative

Date

Effective Date