

REQUEST FOR IMPLEMENTATION

Important: Download this pdf to your computer before typing. If you don't, what you've typed will be lost when saving or printing.

1. Client Information

Client/Firm Legal Name: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____
 Group Tax ID Number: _____

2. Form Completed By

Name: _____ Email: _____

3. Client Administrative Contact (Plan Manager)

Name: _____
 Title: _____
 Email: _____ Phone: _____

4. Client Billing Contact (Billing/Premiums) Check if Same as Administrative Contact

Name: _____
 Title: _____
 Email: _____ Phone: _____

5. Account/Broker Management (Broker/Consultant) Check if Not Working with a Broker

Please note: The Producer and Account Manager will be our contacts regarding policy and renewal information.

Agency: _____ Agency TIN: _____
 Primary Producer: _____
 Email: _____ Phone: _____
 Primary Account Manager: _____
 Email: _____ Phone: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____

Is this being written through a General Agent? No Yes *If yes, complete the following:*

Agency: _____ Agent: _____
 Email: _____ Phone: _____

Is commission being waived? No Yes

6. Plan(s) Selected:

Ultimate Health: Diamond Plus Diamond Platinum
 Plena Health: Emerald Sapphire
 Complamed: Gold Silver
 Requested Effective Date: _____

7. Primary Health Insurance Plan Information: FINAL

This is to confirm that there have been no changes from what was provided during the quoting process. Please provide all final medical, dental and vision plan designs at this time.

Primary Carrier: _____ Benchmark State: _____
 Plan Name: _____ Renewal Date: _____

If writing coverage in MD or TN, base plan cannot be an HMO.

Over-age dependent rider in place? No Yes

Waiver Plans: *For any member waiving the group's primary medical, dental, or vision, we will need their Summary of Benefits submitted. If writing coverage in ND, members waiving the group's primary medical plans are not eligible.*

Dental in place for the company? No Yes

If yes, Carrier: _____ Renewal Date: _____

Vision in place for the company? No Yes

If yes, Carrier: _____ Renewal Date: _____

For any employees enrolled in Medicare Parts A&B, please advise whether they are enrolled in the group's primary health insurance plan or Medicare Supplement Plan with Part D coverage. If writing coverage in ND or TN, the base plan cannot be Medicare.

Primary Health Plan **Supplement Plan w/ Part D**

 **Complete and submit the form by email to submission@armadacare.com or fax to 866-764-2690.**

Underwritten by Sirius America Insurance Company ("Sirius America"). Sirius America has an A.M. Best Financial Strength Rating of "A-" (Excellent) as of March 4, 2020.

