ArmadaCare®

Questions? Call 1-888-260-7189

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 ☐ Gold
Requested Effective Date:

7. Your proposal includes fees for Claim Concierge. Please indicate if you want to opt-out of this program: ☐ Opt-out of Claims Concierge

8. 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: ____________

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.*

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.

☐ **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.

ArmadaCare's third party administrator is Armada Administrators, as authorized by Transamerica Financial Life Insurance Company and Transamerica Life Insurance Company, the underwriter for the ArmadaCare policies.

TRANSAMERICA®