



Group Information

Company Name _____

Company Contact _____ Currently an FBP company? _____

Address _____

County _____ NAIC Code _____

Effective Date _____ Business Type _____

Number of Eligible _____ Other Coverage _____

* All eligible employees MUST be listed on census

REQUESTED	___	Keystone HMO	___	Keystone POS	___	Direct POS	___	Personal Choice
COVERAGE	C	___	F	___	O	___	RX	_____

Agent Information

Agent Name _____

Address _____

Phone number _____ Fax Number _____

E-Mail _____

Name	Zip	Date of Birth	Gender	Family Status*	Waiving
_____	_____	_____	M / F	S P/C H/W F	Y / N
_____	_____	_____	M / F	S P/C H/W F	Y / N
_____	_____	_____	M / F	S P/C H/W F	Y / N
_____	_____	_____	M / F	S P/C H/W F	Y / N
_____	_____	_____	M / F	S P/C H/W F	Y / N
_____	_____	_____	M / F	S P/C H/W F	Y / N
_____	_____	_____	M / F	S P/C H/W F	Y / N

* Family Status - (S) Single, (P/C) Parent/Child(ren), (HW) Husband/Wife, (F) Family

** For additional employees, please complete exact information on the reverse side of this form.