Request for Coverage

CONCIERGE
Third Party Administrator

Date of First Payroll Deduction: _____
Plan Year: _____
Benefit Year: _____
Benefit Effective Date: _____

Group Information

Corporate Name (incl. dba):

Corporate Address

Street: City:

State: Zip: FEIN/SIC:

Who is Eligible for Coverage? Full-time ☐ Part-time ☐ Number of Eligible Employees:

Waiting Period: 30 Days Payroll Frequency: Monthly Administration/Billing: Monthly

Do the billing reports need to be broken down by Regions/Locations/Affilitates? Yes

*If YES, please provide region/location/affiliate name, address, FEIN, and contact name on a separate document.

Group Contact Information

Mailing Address (if different than Corporate)

Street: _____
City: _____
State: _____
Zip: _____

Authorized Singer Plan Administrator:
Title: _____
Phone: _____
Email: _____

Eligibility Contact:
Title: _____
Phone: _____
Email: _____

Billing Contact:
Title: _____
Phone: _____
Email: _____

INTERNAL USE ONLY

Group Number: _____
Product Code: _____

Pay Period Information

Submission Date of last Payrol before effective date: _____
Paid Date of last Payroll before effective date: _____
Submission Date of first Payroll after effective date: _____
Paid Date of first Payroll after effective date: _____

Group Payroll Information

Payroll Contact: _____
Phone: _____
Email: _____
Payroll Vendor: _____
Payroll System: _____
Pay Cycle: _____
Employer Contribution Amount: _____

Agent of Record

Primary: _____
Phone: _____ PEPM
Email: _____

Additional: _____
Phone: _____ PEPM
Email: _____