

New HIF Client Member Profile

Producer: _____

Date: _____

General Information	
Fund Name	
Full Legal Client Name	
Effective Date of Sale	
Lines of Business Medical Pharmacy	Sold ☐ Yes ☐ No ☐ Yes ☐ No
Retail Broker Name	
Retail Broker Status	<i>New or Contracted</i>
Retail Broker Primary Contact	Name: Email: Phone:
Retail Broker Compensation	

Client Information	
Client Address	Street: City: Zip:
Business Administrator or CFO	Name: Title: Phone: Email:

Benefits Administrator or Payroll Administrator	Name: Title: Phone: Email:
Commissioner Contact	Name: Title: Phone: Email:
Privacy Officer	Name: Title: Phone: Email:
Tax ID #	
# Retired Participants	

Retiree Eligibility Information	<i>All fund billing is for the entire month-No prorated billing</i>
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Town Paid or Direct bill Retirees?	<i>Please include a completed census file that needs to include, name, address, DOB, SSN, and pay through date plan enrolled in. If direct billed, please complete the attached direct bill guide</i>
Retiree Eligibility • Medical / Dental / Rx • Surviving Spouse able to continue benefits • Required Number of years of service for retiree benefits	

Contact for Billing: Name: Email: Phone:	<i>Person at the client who will receive the monthly bill,</i>
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Current Plan Information	<i>Please attached a copy of the current plan(s) SPD and the Underwriting Workbook</i>
Medical Carrier	
Prescription Carrier:	

Sold – Fund Information	Sold Rates Quoted Through – xx/xx/xxxx – xx/xx/xxxx
Retiree Plans: Plan Types: Sold Rates:	

Approved and Complete: _____ Date _____
(Producer)

Approved and Complete: _____ Date _____
(HIF Implementation Team)