

For fastest processing, submit this form and any	Fax	Mail		
coverage documents online via support request. You may also use one of the following methods:	608-245-3623	BASIC, PO Box 14015 Madison, WI 53708-0015		

	CLIENT/EMPLOY	ER INFORI	MATION		
					1
Client/Employer Name:			Employer ID (12		
Division: ¹	Employee Coun	t: ²			
Client/Employer Email:			Client/Employe	r Phone:	
If you have multiple branches, subsidiaries or Provide count of employees to determine if Co				-	
	RETIREE BI	LLING SET	UP		
Do not complete this section for COBRA p	lans.				
Will BASIC send election packets for Retire	ee Billing?	☐ Yes ☐] No		
Will Client/Employer charge 102% for pre	miums?	☐ Yes ☐	 ☐ No		
Will Client/Employer charge 150% for disa	ability premiums?	☐ Yes ☐	No (not an option fo	r fully insur	ed plans in MN)
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	PLAN 1 IN	FORMATIC)N		
Plan Name:			Effective Date:		
Plan Type:	ption \square Denta	I □ Visio	n 🗆 Life 🗆 E	AP \square	FSA □ HRA
Plan Setup: ☐ Self-Funded ☐ Fully		A Plans Only) [Plan Year End Date:		
What state is the plan written in?	Are de	endents elig	ible for this plan?	☐ Yes	□ No
When does group coverage terminate?	☐ QE Date ☐	Month End	After QE Date 🔲 O	ther:	
Is this plan bundled with another plan?	□ No □ Yes,	bundled with	n:		
Record detail in the next section. Depending or	n format, bundled pla	n names may	be displayed individuall	y on election	n notices.
Is this an existing plan for which rates and	l setup are not chai	nging?	Yes (no other plan info	ormation ne	eeded) 🗆 No
Is this a new plan? No, rate chan	ge for existing	Yes 🗆 And	replaces:		
Monthly Premium Rates: (Do not include 2	2% administration fee	.)			
If age rated: (Attach table; Date used to	determine particip	ant's age:	☐ Date of Birth ☐	Plan Star	t Date
only indicate plans in use.) Date used to	determine spouse	s age:	☐ Spouse DOB ☐	Participa	nt's DOB
If based on Single	Single + Spouse	Single +			Single + Family
coverage tiers:					
Carrier Name:			Group Number:		
Is this a new carrier? ☐ Yes ☐ No	BASIC performir	g Carrier No	tifications?	☐ Yes (Ca	omplete fields below.)
Eligibility Contact Name:			Contact Title:	(, ,
	ntact Fax:		Contact Email:		
How will BASIC notify Contact?		ontact info c		ewal?	□ Vas □ Na

Authorization Signature Required on Last Page



						PLAN	12 INFO	DRMATIC	N				
Plan Name:									Eff	ective Date:			
Plan Type:	□ Ме	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP							EAP \square	FSA □ HRA			
Plan Setup:	☐ Self-Funded ☐ Fully Insured (FSA Plans Only) Plan Year End Date:												
What state is t	at state is the plan written in? Are dependents eligible for this plan? Yes No										□ No		
When does group coverage terminate?									ther:				
Is this plan bundled with another plan?													
Is this an existing plan for which rates and setup are not changing?									eeded) 🗆 No				
Is this a new plan? No, rate change for existing Yes And replaces:													
Monthly Prem	nium Rat	es: (Do not	t includ	le 2% (administra	tion fee.)						
If age rated: (/			Date	used	to de	termine p	participa	nt's age:	□ Da	te of Birth] Plan Sta	rt Date	
only indicate pla	ans in use.)	Date	used	to de	termine s	pouse's	age:	☐ Spo	☐ Spouse DOB ☐ Participant's DOB			
If based on			Sing	gle		Single + S	pouse	Single +	1 Child	Single +	Children	Single + Family	
coverage tiers	:												
Carrier Name:									Grou	p Number:			
Is this a new ca	arrier?		Yes	□ No		BASIC per	forming	Carrier No	tificatio	ications? No Yes (Complete fields below.,			
Eligibility Cont	act Nam	e:							Cont	act Title:			
Contact Phone	e:				Conta	act Fax:			Cont	act Email:			
How will BASI	C notify C	Conta	ict?	☐ Fa	ах 🗆] Email	Has co	ntact info c	hanged	since last rer	iewal?	☐ Yes ☐ No	
DI ANI O INICODI CATALONI													
						ΡΙΔΝ	I 3 INFO	ORMATIC)N				
						PLAN	I 3 INFO	ORMATIC	N				
Plan Name:						PLAN	I 3 INFO	ORMATIC		ective Date:			
Plan Name: Plan Type:	☐ Med	dical] Pres	cripti		Dental	ORMATIC	Eff	. –	EAP 🗆	FSA □ HRA	
] Pres⊓	•	on 🗆	Dental	☐ Visio	Eff		EAP 🗆	FSA □ HRA	
Plan Type:	☐ Self-	-Fun	ded l	☐ Ful	•	on \square	Dental (FSA	☐ Visio	Eff on C Plan Yea	l Life 🔲 I ar End Date:	EAP	_	
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Plan Name:								Effe	ctive Date:					
Plan Type:	□ ме	☐ Medical ☐ Prescription ☐ Dental ☐ Vision							n 🗆	Life 🗆 E	AP 🗆	FSA	☐ HRA	
Plan Setup:	☐ Self-Funded ☐ Fully Insured (FSA Plans Only) Plan								Plan Year	End Date:				
What state is	s the plan written in? Are dependents eligible for this plan? Yes No													
When does gr	oup cove	rage	term	inate?	? [☐ QE Date ☐ Month End After QE Date ☐ Other:								
Is this plan bu	ndled wit	th an	other	plan?	· [□ No □ Yes, bundled with:								
Is this an exist	hich r	rates a	and set	setup are not changing?										
Is this a new plan? No, rate change for existing Yes And replaces:														
Monthly Pren	nium Rat	es: (Do not	t includ	de 2% a	administra	tion fee.)							
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only indicate pla	ans in use.)	Date	used	to det	termine s	pouse's	age:	☐ Spo	☐ Spouse DOB ☐ Participant's DOB				
If based on			Sing	gle	S	Single + S	pouse	Single +	1 Child	Single + 0	Children	Singl	e + Family	
coverage tiers	:													
Carrier Name:									Group	Number:				
Is this a new c	arrier?		Yes	□ No) E	BASIC per	forming	Carrier No	tification	s? No	☐ Yes (C	omplete f	ields below.)	
Eligibility Cont	act Nam	e:							Contac	t Title:				
Contact Phone	e:				Conta	ct Fax:			Contac	t Email:				
How will BASIC notify Contact?								□ No						
	PLAN 5 INFORMATION													
						PLAN	I 5 INFO	ORMATIC	N					
						PLAN	I 5 INFO	ORMATIC						
Plan Name:									Effe	ctive Date:				
Plan Type:		dical			scriptic	on 🗆	Dental	☐ Visio	Effe	Life 🗆 E	EAP 🗆	FSA	□ HRA	
Plan Type: Plan Setup:	☐ Self	-Fun	ded l	☐ Ful		on 🗆	Dental (FSA	□ Visic	Effe on \Box Plan Year	Life			□ HRA	
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Plan Name:						Effec	tive Date:				
Plan Type:	☐ Medica	al 🗆 Prescrip	otion \square	Dental	☐ Visio	n □ ι	ife 🗆 E	AP 🗆	FSA	□ HRA	
Plan Setup:		nded \square Fully I		(FSA	Plans Only)	Plan Year End Date:					
What state is the plan written in? Are dependents eligible for this plan?											
When does gr	oup coverag	ge terminate?	☐ QE Da	ite 🗆 N	/lonth End	After QE D	ate 🗆 Ot	:her:			
Is this plan bu	ndled with a	nother plan?	า:								
Is this plan bundled with another plan?											
Is this a new p	lan?	No, rate chang	e for existir	ng 🗆 Ye	es 🗆 And	replaces:					
Monthly Prem	nium Rates:	(Do not include 2	% administra	tion fee.)							
If age rated: (A		Date used to	determine p	participa	nt's age:	☐ Date	of Birth 🛚	irth Plan Start Date			
only indicate pla	ans in use.)	Date used to	determine s	spouse's	age:	☐ Spou	se DOB	Participa	ant's DC)B	
If based on		Single	Single + S	pouse	Single +	1 Child	Single + 0	Children	Single + Family		
coverage tiers	:										
Carrier Name:						Group I	Number:	mber:			
Is this a new c	arrier?] Yes □ No	BASIC performing Carrier Notifications?				? □ No	☐ Yes (C	omplete	fields below.)	
Eligibility Cont	act Name:					Contact	: Title:				
Contact Phone	e:	Сог	ntact Fax:			Contact	: Email:				
How will BASI	C notify Con	tact?	☐ Email	Has co	ntact info c	hanged si	nce last ren	renewal?			
If more plans exist, please append another form.											
			ACK	NOWL	EDGMEN	Т					
the month prior date for the rat the month follo earlier than Ma changes in rates	r to the effect e change. If owing the march 1). BAS s before BAS losses in pr	compliance with ctive date. Failure received after the conth for which SIC cannot charg SIC's deadline, you emium difference	e to supply a ne 15th of th rates were ge participa ou may have	any chan ne month received nts for r e to pay t	ges in rates n prior, imp (e.g., rate etroactive the premiu	by this de lementati s received premium m differen	eadline will ron will be d January 20 changes. If ace to your o	result in a elayed un will gene you fail carrier. BA	delay o itil at lea erally bo to com ASIC will	f the effective ast the first of e effective no municate any I not have any	
Signature							 Date				