☐ **NEW HIRE**

Agent Name _____

Company/Employer Name_____

Employer contribution (if available) $ _____Start Month for Contribution_____

Employee Name_____ Employee DOB_____

Address/City/Zip _____

Email _____ Phone _____

To be completed by agent:

Effective Date of Coverage _____ Carrier _____ Member Id#_____

Tax Credit $_____ ICHRA Contribution $ _____ Premium After-tax credit/ICHRA $ _____

☐ **WAIVE (spouse or parent coverage, Medicaid, Medicare, VA, or not interested at this time)**

Employee Name (Print) _____

Employee Signature _____

Date _____

☐ **TERMINATION (PMG must be notified by the 10th of the month to stop premium payments)**

Company/Employer Name _____

Employee Name _____ Termination Date _____

Address/City/Zip _____

☐ **CHANGE OF PREMIUM**

Company/Employer Name _____

Employee Name _____

Tax Credit $_____ ICHRA Contribution $ _____ Premium After-tax credit/ICHRA $ _____

Effective date of change _____

Agent Signature: _____ Date: _____

Or

Authorized Representative Signature: _____ Date: _____

All information should be submitted to:

Karen Scherrer, Premier One Administrator

Email: Kscherrer@pmgagency.com

Phone: 260-755-3585 ext. 102 **Fax**: 260-444-4212