



New Hire

Agent Name _____

Company/Employer Name _____

Employer Contribution (if available) _____ Start Month for Contribution _____

Employee Name _____ Employee DOB _____

Address _____

Email _____ Phone _____

TO BE COMPLETED BY AGENT

Effective Date of Coverage _____ Carrier _____ Member ID _____

Tax Credit (if available) _____ Monthly (After-Tax Credit) Due to Carrier \$ _____

Waive *Spouse or parent coverage, Medicaid, Medicare, VA, or not interested*

Employee Name (Print) _____

Employee Signature _____ Date _____

Termination *PMG must be notified by the 10th of the month to stop premium payments for the following months insurance premium to the carrier*

Company/Employer Name _____

Employee Name _____ Termination Date _____

Address _____

Change of Premium

Company/Employer Name _____

Employee Name _____ Carrier Name _____

Base Premium \$ _____ Tax Credit \$ _____ Monthly FINAL Premium Due to Carrier \$ _____

Effective Date of Change _____ Employer Contribution \$ _____

Agent Signature _____ Date _____

OR

Authorized Representative Signature _____ Date _____

**SUBMIT ALL
INFORMATION TO:**

Karen Scherrer
Premier One Administrator

kscherrer@pmgagency.com
260-755-3585 Ext.102

Fax: 260-444-4212