New Group Set Up

SECTION I — GENERAL INFORMATION

Group Name: ______________________
Contact Name: ______________________
Billing Address: ______________________
City: ______________ **State:** _____ **ZIP:** ______
Phone Number: ______________________
Fax Number: ______________________
Contact Email: ______________________

MUST Representative: ______________________
Agent Name: ______________________
Agent Employer: ______________________
Agent Phone Number: ______________________
Agent Address: ______________________
City: ______________ **State:** _____ **ZIP:** ______
Agent Email: ______________________

SECTION II — GROUP DATA

Tax ID#: ______________________
Legal Name: ______________________
Effective Date: ______________________
Months in Benefit Year: ______________________
Eligibility Hours: ______________________
Medical Deductible and Out of Pocket Maximum Credit:
☐ **Yes** ☐ **No**
Estimated # of Employees Electing MUST Coverage:
Medical: ________ **Dental:** ________ **Vision:** ________
Is Dental and/or Vision Stand-Alone? **YES** **NO**

Basic Life:
(Plan Provided for Active Employees covered under Medical): **$10,000**

Employer Paid Life: ☐ **Yes $**________ ☐ **No**

Voluntary Life (Employee Paid): ☐ **Yes** ☐ **No**

Basic Long Term Disability:
(Plan Provided for Active Employees covered under Medical): ☐ **Buy Up** Employer Paid

# of COBRA: _____ **Retirees:** _____ **Medicare Retirees:** _____
Married Couples: _____ **Trustees:** _____ **Other:** __________

SECTION III — ENROLLMENT

Online **Paper**

Dates:

Preferred Method of Employee Notification:
☐ **Email** ☐ **Memo**
**Employee email list required for email notifications*

SECTION IV — EMPLOYER CONTRIBUTIONS

Enter your Structure Groups (e.g., certified, classified, administrators, etc.).
For additional Structure Groups, please attach an additional sheet.

Structure Groups: ______________________

How much does your district contribute to this Group?

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Dental and Vision: Please enter the amount that is contributed, if any, by the employer.

Dental: ______________________ **Vision:** ______________________