SL Healthplans LLC
Self Funded Marketing Experts

New Business Transmittal Form

Please complete the information below for any accepted cases. Please include a copy of the rate acceptance page along with this transmittal form and e-mail to: stace@slhealthplans.com

Requested Effective Date:

Company Name:

Street Address: **City**:

State: **Zip Code**:

Billing Address: Same as above ☐

City:

State: **Zip Code**:

Company Contact:

Contact Phone Number:

Contact Fax Number:

Contact E-Mail Address:
(Note:E-Mail address is required in order to direct electronic Docu-Sign documents to Employers)

HSA offered through SL Healthplans? **Yes** ☐ **No** ☐

See Next Page

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2. Broker Information

Broker Name:

Agency:

Agency/Broker Tax ID Number:

Broker of Record is: **Broker** ☐ **Agency** ☐

Address:

City: **State**: **Zip**:

Phone:

Compensation:

E-Mail:

(Note:E-Mail address is required in order to direct electronic Docu-Sign documents to brokers)

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3. General Agent Information (when applicable)

General Agent Name:

Agency:

Agency/GA Tax ID Number:

Broker of Record is: **Broker** ☐ **Agency** ☐

Address:

City: **State**: **Zip**:

Phone:

Compensation:

E-Mail:

(Note:E-Mail address is required in order to direct electronic Docu-Sign documents to brokers)