Subdivision Name: _____ DHRM Group Number: Agy:____ Grp:____ Sub____

9. Enter Mailing Address.

Street or P O Box:		Suite:	
City:		State:	Zip+4:

10. Enter Shipping Address (physical location). ☐ Shipping Address same as Mailing Address

Street or P O Box:		Suite:	
City:		State:	Zip+4:

11. Enter Benefits Administrator's information. This is the person who handles eligibility and enrollment, and has primary access to HuRMan.

First Name:		Middle Initial:		Last Name:	Suffix:
Title:					Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -			
Email:					ID or SSN:

12. Enter Benefits Executive's information. This is the person who authorizes the renewal.

First Name:		Middle Initial:		Last Name:	Suffix:
Title:					Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -			
Email:					ID or SSN:

13. Enter Billing Administrator's information. This is the person who receives and handles inquiries about billing.

First Name:		Middle Initial:		Last Name:	Suffix:
Title:					Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -			
Email:					ID or SSN:

14. Enter Billing Executive's information. This is the person who authorizes premium payments.

First Name:		Middle Initial:		Last Name:	Suffix:
Title:					Nickname:
Phone: ( ) -	Ext:	Fax: ( ) -			
Email:					ID or SSN:

15. Employer Certification. I certify that the information on this form is complete and accurate to the best of my knowledge. ☐ Yes ☐ No

Full Name:		Phone: ( ) -		Ext:	
Title:			Date Certified (MM/DD/YYYY):		