Pro-Flex

PRO-FLEX ADMINISTRATORS LLC

Premium Collection Notification Form

Step 1: Employee Information

*=Required Fields

*Employer Name (Do not abbreviate)	*Birth Date (mm/dd/yyyy)

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*Participant Name (First, MI, Last)   *Social Security Number

*Participant Mailing Address   *Benefits Effective Date (mm/dd/yyyy)

*City   *State   *Zip

Step 2: Spouse and Dependent Information

	*Name (Last, First)	*Date of Birth	*Social Security Number
Spouse:			
Dependent:			
Dependent:			
Dependent:			

Step 3: Benefit Information

Carrier Name	Plan Name	Plan Type (Medical/Dental)	Level of Coverage	Monthly Premium
				$
				$
				$
				$

Step 4: Event Information

Leave Start Date: ____/____/____
First month that Pro-Flex will collect premiums: ____/_____

Step 5: Authorization

I hereby state that to the best of my knowledge the above information is correct. Furthermore, I understand that it is my responsibility as the employer to notify Pro-Flex upon an employee's return to work, or termination of employment.

SIGNATURE OF EMPLOYER REPRESENTATIVE:_____ DATE:_____

Please fax this completed form to Pro-Flex Administrators, LLC: 716-929-2013 or toll free 1-855-214-8987
Or Email to: csr@proflextpa.com
Or mail to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221