



Agent Submission Coversheet



180 East Main Street, Suite. 205
Patchogue, NY 11772
1-800-427-5358

Subscriber Company Information

Company Name: _____

Owner/Officer: _____ Title: _____

Billing Address: _____

Company Phone: _____ Fax: _____

EID# or Employer SSN: _____

Health Plan Information

Plan Type: HMO POS

Action: New Group New Enrollee/Emp. Add On

Effective Date: _____

Tier	# Enrollees		Premium		Months Paid	=	Sub Totals
Individual:	_____	x	\$ _____	x	_____	=	\$ _____
Two-Party:	_____	x	\$ _____	x	_____	=	\$ _____
Family:	_____	x	\$ _____	x	_____	=	\$ _____

(Make Checks Payable to ELITE PROGRAMS, INC.) TOTAL COLLECTED \$ _____

Agency Information

Agency Name: _____

Broker/Agent Name: _____

Agency Address: _____

Agency Phone: _____ Fax: _____

Broker/Agent Signature: _____ Date: _____