

**Fort Washington Financial Group LLC
Health Insurance Service Request Form**

Company Name _____ Group No. _____

Person Requesting Service _____ (Signature of Person Requesting Service) _____

Please Add the following Employee/ees to our Group Medical Plan*

Employee Name _____ Date of birth _____ Make Coverage Effective on _____

Employee Name _____ Date of birth _____ Make Coverage Effective on _____

Employee Name _____ Date of birth _____ Make Coverage Effective on _____

*For faster service, FAX a copy of the completed Group Enrollment Application Form with this Service Request Form to (215) 886-1551 and mail the Original Enrollment Application and Service Request Form to our office.

Please Terminate the following Employee/ees below from our Group Medical Plan*

Employee Name _____ ID Number _____ Terminate Coverage on _____

Employee Name _____ ID Number _____ Terminate Coverage on _____

Employee Name _____ ID Number _____ Terminate Coverage on _____

***Make certain to notify terminated employees and dependents of Cobra continuation coverage if applicable.**

Important: Please make sure to review your next monthly billing to make sure your employees have been correctly added or terminated from your plan.

Please issue a new Medical Identification Card for:

Employee Name _____ ID Number _____

Please Mail or Drop Off _____ additional Brochures and Applications for:

Additional Requests or Questions:

**Fort Washington Financial Group, L L C
465 Commerce Drive
Fort Washington, PA 19034**

Telephone: (215) 643-2009

Fax (215) 643-3228