



Dean Health Plan Agent Supply Request Form

Fax to: (608) 827-4152

Business Name: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone #: _____ Contact Email: _____

Date Supplies Needed: _____

Supplies Needed:

(Please indicate the amount needed of each item below)

| | |
|--|------------------------------------|
| _____ Provider Directory | _____ Individual Plan Application |
| _____ Provider Location Map | _____ Conversion Plan Packet |
| _____ Focus General Brochures | _____ Individual Plan Packet |
| _____ HMO General Brochures | _____ Solicitation Disclosure Form |
| _____ POS/POE General Brochures | _____ Waiver of Coverage |
| _____ PPO General Brochures | _____ DeanCare Select Packet |
| _____ HRA General Brochures | _____ DeanCare Gold Packet |
| _____ Employer Group Application | _____ ChamberOne Brochure |
| _____ Health History Group Application | _____ Chamber Group Brochure |

Comments: _____

