

Insurance Contact Information

Group Name:	Primary Administrative Contact:	Title:
Address:	E-Mail:	Phone:

Health Insurance	Name of Current Carrier:	
Supt. Or Chief Administrator	Name:	E-Mail:
	Title:	Fax Number:
	Phone Number:	Address:
ACH Draw	Name:	E-Mail:
	Title:	Fax Number:
	Phone Number:	Address:
Insurance Meeting Notifications:	Name:	E-mail:
	Title:	Fax Number:
	Phone Number:	Address:
Wellness Coordinator:	Name:	E-Mail:
	Title:	Fax Number:
	Phone Number:	Address:
Agent of Record:	Name of Agency:	E-Mail:
	Name of Agent:	Fax Number:
	Phone Number:	Address:

Life Insurance	Name of Current Carrier:	
	Purchase Through SCSC:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of Agent:	
Long Term Disability Ins.	Name of Current Carrier:	
	Purchase Through SCSC:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of Agent:	
Workers Comp. P & C	Name of Current Carrier:	
	Purchase Through SCSC:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of Agent:	
Dental Insurance	Name of Current Carrier:	
	Purchase Through SCSC:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of Agent:	
Vision Insurance:	Name of Current Carrier:	
	Purchase Through SCSC:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of Agent:	

This form was updated on _____ By _____ (Name & Title)

Thank you for your cooperation!

Please e-mail your completed form to: krose@mnscsc.org or mail to Kelsey Rose at the above address, or complete by telephone at 507-389-6999.