Retiree Billing: *Request for Services*

Please complete each item and forward to **Group Dynamic, Inc., 411 U.S. Route One, Falmouth, ME 04105**.
You may also scan and email this information to **clientservices@gdynamic.com** or send via fax to **(207) 781-3841**.

Anticipated Implementation Date: ______________________________

CLIENT INFORMATION	
CLIENT NAME:	
EIN:	
NAICS: (BUSINESS DESCRIPTION)	
PHYSICAL ADDRESS: (STREET/CITY/STATE/ZIP)	
MAILING ADDRESS: (IF DIFFERENT FROM ABOVE)	
AFFILIATED COMPANIES: (NAME/ADDRESS/EIN)	
PRIMARY CONTACT INFORMATION	
CONTACT NAME:	
TELEPHONE NUMBER:	
Please provide fax, email and postal address where confidential information may be sent:	
FAX NUMBER:	
EMAIL ADDRESS:	
MAILING ADDRESS: (IF DIFFERENT FROM ABOVE)	

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR EACH RETIREE PLAN:

If you need additional space, please use the reverse side or a separate sheet

RETIREE MEDICAL PLAN INFORMATION

1. **Medical Plan Effective Date** ______________________________
2. **Medical Plan Renewal Date** ______________________________
3. **Carrier** Name/Address/City/State/Zip ______________________________
4. **Carrier Enrollment & Billing** Contact Name/Phone/Fax/Email Address ______________________________
5. **Plan Name(s),** (e.g., HMO Silver; PPO; POS) ______________________________
6. **Medical Plan Group Number(s)** ______________________________
7. **Monthly Rate information for each tier of coverage** ______________________________
8. **Will coverage terminate if payments are not postmarked within 30 days of the due date?**

   ☐ Yes ☐ No. Payments must be postmarked within ________ days of the due date.

RETIREE DENTAL INFORMATION

1. **Dental Plan Effective Date** ______________________________
2. **Dental Plan Renewal Date** ______________________________
3. **Carrier** Name/Address/City/State/Zip ______________________________
4. **Carrier Enrollment & Billing** Contact Name/Phone/Fax/Email Address ______________________________
5. **Plan Name(s)** (Dental Premier, Dental HMO) ______________________________
6. **Dental Plan Group Number(s)** ______________________________
7. **Monthly Rate information for each tier of coverage** ______________________________
8. **Will coverage terminate if payments are not postmarked within 30 days of the due date?**

   ☐ Yes ☐ No. Payments must be postmarked within ________ days of the due date.

OTHER PLAN INFORMATION

1. **Plan Effective Date** ______________________
2. **Plan Renewal Date** ______________________
3. **Carrier** Name/Address/City/State/Zip ______________________

   ____
4. **Carrier Enrollment & Billing** Contact Name/Phone/Fax/Email Address ______________________

   ____
5. **Plan Name** ______________________

   ____
6. **Group Number** ______________________
7. **Monthly Rate information for each tier of coverage** ______________________

   ____
8. **Will coverage terminate if payments are not postmarked within 30 days of the due date?**

   ☐ Yes ☐ No. Payments must be postmarked within __________ days of the due date.

FEE SCHEDULE

ANNUAL SUBSCRIPTION FEE	$300.00 plus $5.00 per month per retiree

Our staff is available to answer your questions.

SIMPLY CALL US AT

1-800-626-3539

411 US Route One
Falmouth, ME 04105
Tel: (207) 781-8800
Fax: (207) 781-3841
Email: clientservices@gdynamic.com
www.gdynamic.com