Federal Agency Update Form-FEP

Federal Agency Name: _____

Federal Department: _____

County:_____ Hours:_____

Agency Contact/Title:_____ Email:_____

Phone:_____ Fax:_____

Website:_____ Postal District:_____
(For U S Postal only)

Total # Fulltime Employees:_____

Total # employees enrolled with the BCBS Service Benefit Plan:_____

Address Information

Mailing Address: _____

_____

_____

Shipping Address: _____

_____

_____

Please check appropriate box below to receive information

☐ **Health Benefit Officer Quarterly Newsletter**

☐ **Health Education Poster**

☐ **Flu Shot Clinic**

Please email a completed document to: www.fepsales@bcbsnc.com