

**INSTALLATION KIT REQUEST FORM**

\_\_\_\_\_  
**EMPLOYER NAME**

\_\_\_\_\_  
**NUMBER OF EMPLOYEES**

**Number of English Kits** \_\_\_\_\_

**Spanish Kits** \_\_\_\_\_

\_\_\_\_\_  
**EFFECTIVE DATE**

**PLEASE FAX TO (559) 635-6527 OR EMAIL To pcortez@benelect.com**

**Carrier Name:** \_\_\_\_\_ **Carrier Plan:** \_\_\_\_\_ **Carrier Deductible:** \_\_\_\_\_

**Benny Card:** Y N

**Ben-e-lect Self-Funded Benefits-**

**Deductible:**

0      250      500      **Other:** \_\_\_\_\_

**Co Insurance:** 50      60      70      80      90      100

**Out of Network Co Insurance:**      50      60      70      80      90      100

**Office Visit Copay:** \$ \_\_\_\_\_ or \_\_\_\_\_ %

**Prescription Copay:** \$ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Note any additional special benefits out of network or after deductible benefits**

**Additional Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Needed by Date:** \_\_\_\_\_

**Send to:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DENTAL # of kits needed** \_\_\_\_\_

***PLAN SELECTED:*** *Please circle one*

*\$500 100/80/50 with ortho*

*\$500 100/80/50 without ortho*

*\$250 100/80/50 with ortho*

*\$250 100/80/50 without ortho*

*The Installation kits were designed to streamline your employee meetings and make them last no more than 30 minutes. You will see the material we have incorporated into the kit is easily understood and made to simplify your meeting.*