An Independent Licensee of the Blue Cross and Blue Shield Association

AGENCY/PRODUCER TRANSMITTAL REPORT

120 Fifth Avenue, Suite 1025 • Pittsburgh, PA 15222-3099

TODAY'S DATE: _____

EFFECTIVE DATE: _____

AGENCY/PRODUCER NAME: _____

AGENCY CODE NUMBER: _____

SUPPLEMENTAL PLAN

V = VISION

BASIC PLAN CODES

1 = INDIVIDUAL
2 = PARENT & CHILD
3 = PARENT & CHILDREN
4 = HUSBAND & WIFE
5 = FAMILY

Only two premium levels (Individual and Family) exist for the one Supplemental Plan. Specify any coverage purchased by coding either a **1** for Individual or a **5** for Family in the appropriate box.

COMPANY NAME: _____

EMPLOYEE'S NAME (LAST) (FIRST) (MI)	HEALTH PLAN CODE	HEALTH PLAN PREMIUM	SUPPLEMENTAL PLAN V	SUPPLEMENTAL PLAN PREMIUM	TOTAL PREMIUM
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
		$		$	$
TOTAL EMPLOYEES →		**TOTAL PREMIUM →**			$

Return this form, along with completed Small Group Business Application, UC-2, Employee Enrollment Forms, and initial premium to: Highmark Blue Cross Blue Shield, 120 Fifth Avenue, Suite 1025, Pittsburgh, PA 15222-3099

ATTENTION: SMALL GROUP SUBMISSION