# Small-Group Employer Order Form

Please fill out the information below and fax to the attention of Operations Support Department at 860-674-5728. Requests for supplies take approximately 5 working days. **Orders cannot be shipped to P.O. Boxes.** Please print clearly.

Company Name _____

Requester Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Group Number _____ Plan Name _____

**Group number & plan name MUST be filled out to complete this request!**

Quantity

_____ Provider Directory
_____ ConnectiCare Dental Provider Directory (Value, Plus, Premium) – Circle choice(s)
_____ Enrollment/Change Forms - Connecticut
_____ Enrollment/Change Forms - Massachusetts
_____ Enrollment/Change Forms - ConnectiCare Dental
_____ Out-of-Plan Reimbursement Claim Form
_____ Family Health Statements
_____ Benefit Summaries
_____ Pharmacy Summary
_____ Vision Care Flyer
_____ Guidebook
_____ Other: _____

**Fax for prompt service.**

ConnectiCare®
*You know us by ♥.*

SG.Order 04/08