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: _______________________________________

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Shipping Address: _______________________________________

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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