Starmark®

Report Request Form

Name of Requestor: _____

Group Name: _____

Group Number: _____

Relationship to Group: ☐ MGA ☐ Agent ☐ Group Administrator ☐ Employer

Agent Social Security No. (if applicable): _____

Phone Number: _____

Type of Report Requested:

☐ **Deductible Credit** — Lists deductibles accumulated during a specific time frame.
☐ **Coinsurance Accumulation** — Identifies coinsurance accumulated during specific time frame.
☐ **Renewal Loss Ratio** — Available only to the assigned managing general agent for the group requested. Limited to one request during the contract year.
☐ Other _____

Reason for Request: _____

_____

Preferred Method to Receive Report:

☐ **Fax,** Please list fax number: _____

☐ **By Mail,** Mailing address:

_____

_____

I understand the information contained in the requested report is confidential and may be used only for purposes relating to obtaining and maintaining group health benefit plan coverage.

Signature: _____ Date: _____

Fax completed forms to 330.965.7599, Attn: Customer Service Supervisor, or mail to: Starmark, Attn: Customer Service Supervisor, P.O. Box 2942, Clinton, IA, 52733-2942

For Starmark Use Only:

Authorized Group Representative	_____ Yes	_____ No
Authorized Report	_____ Yes	_____ No
Report Generation Request Date	_____	
Report Distribution Date	_____	