

Agency Name: _____

Point of Contact: _____

Title: _____

Mailing Address: _____

Email: _____

Work #: _____

Fax #: _____

Mobile #: _____

Does your Agency sponsor an annual health benefits fair? Yes No

When available, please mail or email your Agency's Health Fair invitation:

- Health Fair Date and Times
- Health Fair Location
- Shipping Preference
- Security Details

For Brochures only, please indicate the number of materials needed: _____

PLEASE RETURN THIS COMPLETED QUESTIONNAIRE TO:

Fax to: 410-424-1572 or

mail to: APWU Health Plan, Attn: Maurice Glover, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061
mglover@apwuhp.com

Note: This information will not be shared outside of APWU Health Plan

APWU Health Plan • 1-800-222-2798 (Membership Services) • www.apwuhp.com

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