APWU HEALTH PLAN

Health Benefits Specialist/Agency Questionnaire

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