Dean Health Plan
Supply Request Form

Fax to: (608) 827-4152
Attn: Georgia Varebrook

Mail to:
PO Box 56099
Madison, WI 53705

Date supplies are needed by: _____

Send to:

Company Name: _____ Attention: _____

Group Number: _____ Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please indicate the number of items needed:

_____ New Hire Packet Include: _____ Plan Brochure
_____ Application
_____ Provider Map
_____ RX Exclusion List
_____ Benefit Outline
_____ Provider Directory
_____ Other

_____ Provider Directory
_____ Group Application (2003-0409)
_____ Waiver of Coverage Form (2006-0403)
_____ Senior Select Plan Packet (Medicare Supplement Plan)
_____ Individual Plan Packet (Individual Health Insurance Plan)