

# 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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Shipping Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check appropriate box below to receive information**

Health Benefit Officer Quarterly Newsletter

Health Education Poster

Flu Shot Clinic

Please fax completed document to: 919.765.3888 or email to: [www.fepsales@bcbsnc.com](mailto:www.fepsales@bcbsnc.com)