

We cordially invite you to become a member of Northeast Business Group on Health!

PLEASE NOTE: Membership dues are based on the type of organization and the number of employees nationally. Dues are payable by January 1st for the calendar year. Upon receipt of this application, a member of our staff will contact you by phone to provide you with additional dues information.

Company/Organization Name:

What type of organization are you?

- | | |
|--|---|
| <input type="checkbox"/> Employer | <input type="checkbox"/> Pharmacy Benefit Manager |
| <input type="checkbox"/> Healthcare Provider (eg: Hospitals, Healthcare Systems, Medical Groups, etc.) | <input type="checkbox"/> Pharmaceutical |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Related (Healthcare products and services) |
| <input type="checkbox"/> Health Plan | <input type="checkbox"/> Nonprofit |

How many employees does your organization have nationally?

How did you hear about NEBGH?

- | | |
|---|--|
| <input type="checkbox"/> Email | <input type="checkbox"/> Referral: _____ |
| <input type="checkbox"/> NEBGH Website | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> NEBGH Newsletter | |

HEALTH PLAN AND PBM USER GROUPS: To help us better design our programs, please let us know which of the following companies you currently work with. Check all that apply.

Health Plans:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Aetna | <input type="checkbox"/> EmblemHealth | <input type="checkbox"/> UnitedHealthcare |
| <input type="checkbox"/> Anthem BCBS | <input type="checkbox"/> Horizon BCBS of NJ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cigna | <input type="checkbox"/> Kaiser | |

Consultants:

- | | | |
|---|---|--|
| <input type="checkbox"/> AonHewitt | <input type="checkbox"/> Lockton | <input type="checkbox"/> Towers Watson |
| <input type="checkbox"/> Buck Consultants | <input type="checkbox"/> Mercer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gallagher | <input type="checkbox"/> PricewaterhouseCoopers | |

PBMs:

- | | | |
|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Caremark | <input type="checkbox"/> ExpressScripts | <input type="checkbox"/> Other: _____ |
|-----------------------------------|---|---------------------------------------|

Other Vendors:

- | | |
|-----------------|--------------------------|
| Dental: _____ | Behavioral Health: _____ |
| Vision: _____ | Workers' Comp: _____ |
| Wellness: _____ | Disability: _____ |

PRIMARY CONTACT: Each member company should designate one individual as the primary NEBGH contact liaison for billing and other communications. Following contact by our staff, this contact liaison may also specify secondary contacts who will receive NEBGH mailings and participate in NEBGH activities.

Name:

Job Title:

Address:

City:

State:

Zip Code:

This location is a: Headquarters Local Office Telecommuting/Home Address Other

Telephone:

Fax:

Email:

I would like to list our company/organization on NEBGH's website membership list. Yes No

Please state briefly the business function of your organization:

SECONDARY CONTACTS: If you have more than two contacts you'd like to include, please list under separate cover. Email subscriptions can be updated at any time.

Name:

Job Title:

Address:

City:

State:

Zip Code:

Telephone:

Fax:

Email:

NEBGH Email Subscriptions: Monthly Newsletter Health Policy Dispatch Event Updates

Name:

Job Title:

Address:

City:

State:

Zip Code:

Telephone:

Fax:

Email:

NEBGH Email Subscriptions: Monthly Newsletter Health Policy Dispatch Event Updates

Please submit this application to: Lauren Danzig at ldanzig@nebgh.org.