



## EMPLOYER SET-UP FORM

**Instructions:** Please fill out any information in Sections 1 and 2, where applicable. Employees are required to sign and date at the bottom of the form. If an employee has an Authorized Representative, the AR must also sign and date the form. Please submit the completed form to **AssuranceSD** via one of the following options below:

**Mail:**  
515 South 700 East,  
Suite 2B  
Salt Lake City, UT 84102

**Email:**  
UT@premier-fms.com

**Fax:**  
(855) 500-4521

### EMPLOYER'S INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ County: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### PERSON RECEIVING SERVICES

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ County: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### AUTHORIZED REPRESENTATIVE INFORMATION (If applicable)

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection.

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_