



Protecting Employers' most valuable asset: **Employees**

**Employer Notification Affirmation
of Medical Provider Network (MPN)
Written Notification to Employees**

Insured Name:
Policy Number:

(Below is the individual or Manager who was responsible for the MPN communication to the Insured's Employees.)

Name:
Business Location:
Phone:

Method used to communicate the MPN Notification Information:

Please circle one:

- 1. US Mail 2. Payroll Stuffer 3. All Employee Meeting
- 4. Individual Distribution 5. Email

Date distributed to employees: _____

As the designee for _____, I have received written notification of the Medical Provider Network (MPN) and distributed the notification information to each employee of record and agree to provide the MPN notification of rights information to new employees.

Signature

Date

Print Name

**PLEASE FAX SIGNED AGREEMENT TO:
TECIS INSURANCE SERVICES
(805) 682-4140**