Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, RI 02903-2699
www.BCBSRI.com

Blue Cross & Blue Shield of Rhode Island
Broker Service Fees Agreement
Notice of Service Fee Change

Group number: ___________ Group Name: ____

Broker Number: ___________ Broker Name: ____

Broker Address: ____

Requested Effective date*: _____________

**Service fee will be effective the first of the month following submission of this Notice to BCBSRI or the requested effective date, whichever is later.*

Section 1: Complete this section to change service fee

Flat Dollar Per Month	
Monthly Service Fee:	

Per Employee/Per Product Line/ Per Month		
	Product Line**	**Per Employee Per Month**

***Product Line refers to the medical, dental and vision lines of business. Please fill the field in with the applicable product line(s) for the group.*

Section 2: Select box to cancel a service fee:

☐ Cancel Broker Service Fee

____

Group: _______________________________________

Signature: ____________________________________

Name:____

Title: ____

Date: ____

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.