Department of Employee Trust Funds

P.O. Box 7931

Madison, WI 53707-7931

**FORM F**

**Vendor References**

**ETI0047 Third Party Administration of the Wisconsin Public Employers Group Life Insurance Program**

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| **Proposer Company Name:** Click or tap here to enter text. |

Instructions: Provide the requested information for a minimum of four (4) entities for which you have provided, or currently provide, services that are similar to the services requested in this RFP. At least one reference should be an entity with enrollment of at least 10,000 employees. At least one reference should be an entity that recently (within the last 3 years) became a client (to speak to their experience with implementation of your organization’s services). Do not include the State of Wisconsin as a reference.

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| Entity Name: Click or tap here to enter text. | | |
| Contact Person Name and Title: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |
| Plan(s)/services offered through Proposer and number of employees: Click or tap here to enter text. | | |

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| Entity Name: Click or tap here to enter text. | | |
| Contact Person Name and Title: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |
| Plan(s)/services offered through Proposer and number of employees: Click or tap here to enter text. | | |

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| Contact Person Name and Title: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |
| Plan(s)/services offered through Proposer and number of employees: Click or tap here to enter text. | | |