Department of Employee Trust Funds

P.O. Box 7931

Madison, WI 53707-7931

**FORM F**

**Vendor References**

**ETJ0043 Third Party Administration of the State of Wisconsin Income Continuation 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 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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| Company Name: Click or tap here to enter text. |
| Contact Person Name and Title: Click or tap here to enter text. |
| Phone: | Email address: |
| Address: Click or tap here to enter text. |
| City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip Code: Click or tap here to enter text. |
| List of products/services you provided to this company: Click or tap here to enter text. |

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| City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip Code: Click or tap here to enter text. |
| List of products/services you provided to this company: Click or tap here to enter text. |