New Client Registration Form

Please complete the following form. This will enable us to quickly register any injured employee from your company. This will also serve as a starting point to registering Prevention services. Please FAX or EMAIL this completed form back to (207) 780-6320 or opsdirector@behc.net, the Director of Operations or Client Relations will follow up with a call or email if we need additional information. Thank you.

Company Name _____
Address: _____
_____
_____
_____

Phone: _____
Fax: _____ **secure: Yes or No**
Email: _____

Worker's Compensation Carrier/TPA: _____
_____
_____
_____

Number of Employees: _____
Industry: _____
Safety Program: **Yes or No**
Company Contact for Prevention Services: _____
Company Contact for Injury Management: _____

Please write a brief description of services in which your business is seeking:

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Have you ever had a Worker's Compensation Preferred Provider? **Yes or No**