

Please use this as a guide to ensure that the proper information is submitted for all New Business:

For all New Business:q **Preliminary Application for Group Insurance**

- Original, signed & dated by effective date by **both** Employer and Broker

There are state specific versions for: AR, CO, DC, FL, KY, LA, ME, MN, NJ, NM, NY, OH, PA, VA

q **Confirmation of Plan Information form**q **Deposit check** equal to approximately 1st month's premiumq **Copy of Sold Proposal**q **Updated Census List (in Excel format)**

- **This Excel file is mandatory for on-line billing (list billed and self-administered) as well as for paper list bills.**
- This file is in lieu of cards with applicable info (for contributory cases, Employer holds enrollment cards with waiver info.)
- **Your Regional Sales Office will assist you in reviewing the fields needed in Excel file based upon coverages elected.**

For Takeover Business:q **Prior carrier Booklet**

- This will allow us to review all of the provisions in the prior plan. This is especially important for claim processing.

q **Prior carrier Bill**

- We will compare prior bill to the first bill that we generate and discuss any discrepancies in volumes and number of lives.

If Applicable:q **Evidence of Insurability**

For Employers who **select our on-line enrollment option**, employees and spouses will answer medical questions on-line and will receive a message if paper submission of our medical questionnaire is required.

For Employers who **do not select** our on-line enrollment option, forms are required for:

- employees & dependents applying for amounts greater than non-medical maximum or late enrollees
- employees not on prior contributory plan who did not enroll within 31 days of eligibility (late entrants)

q **Questionnaire(s):** q **Bonus Formula** (if in Earnings Definition) q **Travel Accident (SR)** q **Aircraft/Crew Member (SR/VAR)**q **Telephonic Claim Intake Client Notification Form** (option for STD/TDB/DBL 250+ lives)q **Domestic Partner Coverage:** Please submit a copy of a blank Affidavit of Domestic Partnership used by the Employerq **For Unions:** If union employees are to be covered, please provide all applicable pages of the Collective Bargaining Agreement(s).q **For Hawaii TDI, New Jersey TDB & New York DBL:**

- q **Hawaii TDI** application: TDI-APP-1003
- q **New Jersey TDB** application: TDB-APP-0801 & state form DP-1
- q **New York DBL** application: DBL-APP-0103

Important Note on W-2 preparation: W-2's (including Employer FICA match) are automatically produced at no additional cost for **LTD**. For **STD** (including DBL, TDB & TDI), W-2 preparation is an option (at an additional cost – see proposal details). If Reliance Standard W-2 preparation is not selected, the Employer will be responsible for preparing STD W-2's and making Employer FICA match.

Employer Information (to supplement Preliminary Application)	Full Legal Name of Group: <small>(exactly as to be shown in contract with exact abbreviations, punctuation, or capitalization)</small>		Website Address:		
	Executive Contact Name:		Tax ID #:		
	Phone #: _____ Fax #: _____	Routine Contact Name:	Phone # : _____ Fax #: _____		
	E-mail address: _____	E-mail address: _____			
Location: <input type="checkbox"/> Main <input type="checkbox"/> Other:		Location: <input type="checkbox"/> Main <input type="checkbox"/> Other:			
When did Company Operations begin ? Month _____/Year _____					
100+ lives: Should we use Policy Anniversary as reporting date for 5500? <input type="checkbox"/> Yes (<i>standard</i>) <input type="checkbox"/> No, use _____					
Form completed by (print name): _____ <input type="radio"/> Employer <input type="radio"/> Broker <input type="radio"/> G.A. /T.P.A. <input type="radio"/> Other: _____ 					
Is other group coverage(s) in force with Reliance Standard ? <input type="checkbox"/> No <input type="checkbox"/> Yes - Reliance Standard Group #: _____					

Billing	Bill Delivery & Employee Eligibility Method:	<input type="checkbox"/> On-Line List Billed (Employer maintains eligibility data on-line, real time) <input type="checkbox"/> On-Line Self-Administered (Employer maintains eligibility data & reports volume, lives & premium totals on-line) <input type="checkbox"/> Paper List Billed <100 lives (Reliance maintains eligibility data, mails bills, changes sent to Reliance Standard) <input type="checkbox"/> Paper Self-Administered (Employer maintains eligibility data & reports volume, lives & premium totals via mail) <input type="checkbox"/> TPA billing: Name: _____ Address: _____
	Please note that we need an up-to-date census listing so that we can accurately prepare your first bill.	
	Premium Payment Options:	<input type="checkbox"/> Check <input type="checkbox"/> Wire Transfer /ACH Credit - You transfer funds to Reliance Standard's bank account <input type="checkbox"/> ACH Debit (only available for on-line billing) - You authorize Reliance to deduct funds electronically from account
	Bills will go to each Correspondent as noted below. If more than three bill groups, please supply details on a separate page. 1st Bill Group: Billing Group Name (optional): _____ <input type="checkbox"/> Routine Correspondent listed on Preliminary Application OR Correspondent: _____ Title: _____ Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____ Phone: _____ Fax: _____ Email: _____	
2nd Bill Group: Billing Group Name (optional): _____ Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____ Correspondent: _____ Title: _____ Phone: _____ Fax: _____ Email: _____		
3rd Bill Group: Billing Group Name (optional): _____ Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____ Correspondent: _____ Title: _____ Phone: _____ Fax: _____ Email: _____		

Life Coverage(s):		Basic		Dependent	Supplemental		Voluntary	
		Life p	AD&D p	Life p	Life p	AD&D p	Life (VG) p	AD&D (VAR) p
Sold Rate(s):					p Step rates attached		p Step rates attached	Employee Rate:
		per \$1,000		/ dep. unit				Family Rate:
Employer Contributions (%):								
For Contributory Coverages:	Payroll Deductions:	p Weekly		p Bi-weekly	p Semi-monthly		p Monthly	
	Total Eligible Employees:							
	Total Participating Employees:							
	Flex / Section 125?	pN pY	pN pY	pN pY	pN pY	pN pY	pN pY	pN pY

Disability Coverage(s):		Short Term				Long Term	
		STD p	Voluntary STD(VPS) p	New York DBL p	New Jersey TDB p Hawaii TDI p	LTD p	Voluntary LTD (VPL) p
Sold Rate(s):			p Step rates attached	\$_____ Male	per \$10	per \$100	p Step rates attached
		per \$10		\$_____ Female			
Employer Contributions (%):							
For Contributory Coverages:	Payroll Deductions:	p Pre-Tax r Post-Tax Amount: \$_____	p Pre-Tax r Post-Tax Amount: \$_____	\$.60 / week p Pre-Tax r Post-Tax	p Pre-Tax r Post-Tax Amount: \$_____	p Pre-Tax r Post-Tax Amount: \$_____	p Pre-Tax r Post-Tax Amount: \$_____
	Please ask us for guidance with additional disability taxation options.						
	Total Eligible Employees:						
	# Participating Employees:			All must be covered			
Flex / Section 125?		pN pY	pN pY	pN pY	pN pY	pN pY	pN pY

Voluntary Coverages

Completion of this form confirms agreement to implement the aforementioned Reliance Standard Voluntary Coverage(s).

Eligible employees to be solicited starting on _____ through _____. After enrollment, coverage will be effective _____;

Beginning Payroll Cycle: Start date of first pay period: _____ End date of first pay period: _____

Starting Age Band for Step Rates: p < Age 20 p < Age 30

We will prepare brochures and employee enrollment applications with the Employer's name and policy number. Brochure rates **match** payroll deduction mode (in rate section above) unless otherwise noted; bills will reflect **monthly** rates.

Please start payroll deductions immediately for total requested amounts - including amounts above the Guaranteed Issue limit.

For VG (Voluntary Life only) Rate Type: p Tobacco Use/Non-Tobacco p Undifferentiated

Future eligible employees will be effective: p 1st of month p 1st of the 2nd month following date application is signed

Travel Accident (Special Risk) (SR) p	_____ Employees Covered
	Premium: p 1 Year p 3 Year p 5 Year p Prepaid p Annual Installments \$ _____

Employee Eligibility, Service Waiting Period & Earning Definition(s) (if different by coverage, please note)

Please select an eligibility description either for all employees (Class 1 box) **or** for each class as appropriate:
 Note: All Classes standardly exclude temporary or seasonal employees.

Class 1	# of Hours worked per week: <input type="checkbox"/> Full-time hours: _____ <input type="checkbox"/> Part-time hours: _____ (if eligible)	Includes: <input type="checkbox"/> All Employees OR <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> Other Description: (Ie., Officer, etc...)
Class 2	# of Hours worked per week: <input type="checkbox"/> Full-time hours: _____ <input type="checkbox"/> Part-time hours: _____ (if eligible)	Includes: <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> Other Description: (Ie., Officer)
Class 3	# of Hours worked per week: <input type="checkbox"/> Full-time hours: _____ <input type="checkbox"/> Part-time hours: _____ (if eligible)	Includes: <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> Other Description: (Ie., Officer)

Other: (Attach page listing other eligibility categories or classes, if applicable)

Employee Service Waiting Period: (time employee must work before becoming eligible for insurance coverage)* n/a SR (Travel Acc.)
 No service wait 30 Days 60 Days 90 Days 1 Month 3 Months Other:

*For present employees covered by prior plan (on policy effective date), time employed is credited towards service wait

Individual Effective Date: (coverage effective date once service waiting period is complete) (see page 2 for voluntary coverage options)
 On the Date S.W.P. is completed 1st of the Month coinciding with or next following S.W.P. Other:

Class Specific Waiting Periods(if applicable): Class 1: _____ Class 2: _____ Class 3: _____

Individual Termination Date: (see page 2 for voluntary coverage options)
 Employee Term. Date 1st of Mo. or Last Day of Mo. coinciding w/ or following Term. Date Other

Reinstatement Date: (not applicable for voluntary life)
 Must employee returning from an **approved** leave of absence/lay-off **re-satisfy** Service Waiting Period?
 No, if returning within 6 months (*standard*) Yes Other:

Benefit Change Date	<input type="checkbox"/> 1st of Month: Age, Class & Earnings changes effective the 1st of month coinciding with or next following change date <input type="checkbox"/> The Date: Age, Class & Earnings changes effective on the date of change <input type="checkbox"/> Other:
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Earnings Definition	Applicable to Class(es) or Coverage(s): <input type="checkbox"/> All <input type="checkbox"/> Other:
<input type="checkbox"/> Basic Earnings Only - (standard) - "Earnings": basic salary, prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Excluding: commissions, overtime, bonuses or any other special compensation not received as basic salary.	
<input type="checkbox"/> Basic Earnings including - "Earnings": basic salary, prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Including: <input type="checkbox"/> Bonuses <input type="checkbox"/> Commissions <input type="checkbox"/> Overtime <input type="checkbox"/> Incentive Pay Averaged over <input type="checkbox"/> 3 years (<i>standard</i>) <input type="checkbox"/> 2 years <input type="checkbox"/> One Year (n/a for GL (Life), VAR (Vol. AD&D) or SR (Travel Accident). Averaging applies to: <input type="checkbox"/> All Employees <input type="checkbox"/> Salespeople <input type="checkbox"/> Commissioned Employees <input type="checkbox"/> Officers <input type="checkbox"/> Other:	
<input type="checkbox"/> W2 Earnings prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Including: <input type="checkbox"/> Bonuses <input type="checkbox"/> Commissions <input type="checkbox"/> Overtime <input type="checkbox"/> Incentive Pay <input type="checkbox"/> Prior Year or Averaged over <input type="checkbox"/> 3 years (<i>standard</i>) <input type="checkbox"/> 2 years Averaging applies to: <input type="checkbox"/> All Employees <input type="checkbox"/> Salespeople <input type="checkbox"/> Commissioned Employees <input type="checkbox"/> Officers <input type="checkbox"/> Other:	
Please submit Bonus Formula Questionnaire for any definition(s) that includes bonuses.	
<input type="checkbox"/> Use K1 Earnings for Partners: <input type="checkbox"/> Prior Year or Averaged over: <input type="checkbox"/> 3 years (<i>standard</i>) <input type="checkbox"/> 2 years	
<input type="checkbox"/> Include S Corp wording: <input type="checkbox"/> Prior Year or Averaged over: <input type="checkbox"/> 3 years (<i>standard</i>) <input type="checkbox"/> 2 years	

Booklet/Contract Printing	<input type="checkbox"/> Electronic, provided in Adobe PDF (standard)* <input type="checkbox"/> 5 ½ X 8 ½ Booklets* <input type="checkbox"/> 8 ½ X 11 Flat Certificates (no cover)* Include: <input type="checkbox"/> Company Logo (.tif format – 300 d.p.i) <input type="checkbox"/> Agent Name <input type="checkbox"/> Other: _____		
	* Flat Certificates are the only option for Voluntary Lines (Life/STD/LTD & SR (Travel Accident)).		
	<input type="checkbox"/> Same for Entire Group, combine multiple coverages (if applicable) (standard) *Note: there is a maximum of 2 coverages combined per booklet; coverages cannot be combined in certificates.		
	<input type="checkbox"/> by Class <input type="checkbox"/> by Coverage <input type="checkbox"/> by Affiliate		
Mail to:	<input type="checkbox"/> Policyholder's Routine Correspondent (standard) <input type="checkbox"/> Broker <input type="checkbox"/> Other: _____ Booklet mailing instructions for multiple locations, if applicable: Administration Kit will be mailed per above instructions unless otherwise noted.		

ERISA/SPD	Include Summary Plan Description (SPD) in addition to standard ERISA wording ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: ERISA plan number(s): Life _____ STD _____ LTD _____		
	Plan Administrator: <input type="checkbox"/> Employer (standard) <input type="checkbox"/> Union Maintaining Plan <input type="checkbox"/> Other - Administrator Name & Address: _____		
	How are Plan Records kept?: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Fiscal Year _____ <input type="checkbox"/> Policy Year (Anniv.)		

Family Medical Leave Act	Include FMLA coverage continuance provision?: <input type="checkbox"/> Yes <input type="checkbox"/> No (n/a for SR, STD, DBL, TDB & TDI)
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Disability Claim Information: (Cumulative Monthly Case Summaries are automatically distributed for all STD & LTD claims)	Check Issuance: <input type="checkbox"/> Claimant, copy Policyholder (standard) <input type="checkbox"/> Claimant <input type="checkbox"/> Policyholder
	W-2's (including Employer FICA match) are automatically produced at no additional cost for LTD . For STD (including DBL, TDB & TDI), W-2 preparation is an option (at an additional cost – see proposal details)
	Who will prepare STD W-2's and make Employer FICA match: <input type="checkbox"/> Reliance Standard <input type="checkbox"/> Employer
	Claims Reports are mailed to the Routine Correspondent. Please advise of other instructions.
STD Telephonic Claim Intake?: (50 + lives) <input type="checkbox"/> No <input type="checkbox"/> Yes - will you supply eligibility feed? <input type="checkbox"/> No <input type="checkbox"/> Yes	

ASO STD Only:	Full ASO <input type="checkbox"/> Advice to Pay (ATP) <input type="checkbox"/> Fee per claim: \$ _____ Claim Payor Assist <input type="checkbox"/> Rate: \$ _____/employee
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Primary Broker Name (as shown on license) _____ Share % : _____ Full Address: _____ Contact for ?s: _____ Phone: _____ Fax: _____ E-mail: _____

<input type="checkbox"/> Individual	Individual SS #: _____ DOB: _____
<input type="checkbox"/> Corporation	Corporate Tax ID #: _____ Broker Name (as shown on license) _____ SS#: _____ Currently appointed with Reliance Standard in situs state? <input type="checkbox"/> No <input type="checkbox"/> Yes, Agent # _____ (if available) If no, please attach license copy. Our Licensing Dept. will provide appointment package for completion.

Additional Broker Name (as shown on license) _____ Share % : _____
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Please provide information as listed above for all additional brokers.	
(if applicable) <input type="checkbox"/> G.A. <input type="checkbox"/> T.P.A. _____ Tax ID #: _____ Agreement on file with Reliance Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact for questions: _____ Phone: _____	