A member of the Generali Group

BMA SOLD CASE CHECKLIST

The following items must be obtained upon enrollment of a new group account. Enrollment must be submitted no later than 10 days after the effective date of coverage. **Complete information will expedite processing!**

- ❐ Completed Master Application for Group Insurance (A 01 00002 in most states, A 01 00004 in Kentucky/Ohio, A 01 00005 in Florida, A 01 00006 in Mississippi, A 01 00008 in Pennsylvania and A 01 00014 in Maryland.
- ❐ Enrollment Cards or Census Listing – Information must include: Insured's full name, SS#, date of birth, sex, date of hire (optional if no waiting period), applicable division or class, earnings (if salary based benefit), and EE & Dep coverage selections.
  Dental – Must also include occupations, dependents' full names and relationship to insured, dependents' sex, and dependent birthdates (if dependent coverage selected)
  LTD – Must also include occupations.
  ***The waiver section should be completed on signed enrollment cards for any person declining Employee or Dependent benefits.**
- ❐ Copy of last invoice from prior carrier (if replacing coverage)
- ❐ Copy of prior plan – master contract or certificate (if replacing coverage)
- ❐ Initial month's premium
- ❐ **Please attach copy of benefits and rates sold.**
- ❐ **LTD** – Must have a copy of the commission or bonus plan schedule, if applicable. Commissions & Bonuses will be averaged over 24 or 36 months, unless Underwriting approval is received.

Group Name: ______________________ Effective Date: ____________

Routine Contact: ______________________

Phone: ____________ FAX: ____________ E-mail Address: ____________

Executive Contact: ______________________

❐ List Bill ❐ Self Administered Bill ❐ Billed by Divisions ❐ Short Form Accounting

Description of employee eligibility:

❐ Standard: Full-time, active employees working at least 30 hours/week.

❐ Other: ______________________

Waiting Period for:

❐ Employees actively at work on or before BMA effective date: ❐ 30 ❐ 60 ❐ 90 days ❐ Other ________

❐ New Employees actively at work and who have not met new employee waiting period or were hired after BMA effective date: : ❐ 30 ❐ 60 ❐ 90 days ❐ Other ________

❐ Effective 1st of the month following Waiting Period.

❐ Effective immediately after Waiting Period.

❐ Termination effective last day of policy month (not available on STD and LTD).

❐ Termination effective upon termination of employment.

Send Administration Manual via: ❐ e-mail (address: ______________________) or ❐ CD-Rom (System Requirements: 32-bit Windows (Windows 95, 98 or NT 4.0 or greater); and CD Reader or Internet Explorer 4.0 or greater; Netscape 4.0 or greater)

Mail Certificate Booklets to: ❐ Employer ❐ Producer (e-mail address: ______________________)

For Cases with 100+ Employees: ❐ Include ERISA Plan info for using cert as SPD.

Agent for Legal Process: ______________________ Plan Number: ____________

Employer ID #: ____________ Plan Year Ends: ____________ Plan Administrator: ____________

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BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA (BMA)
Box 419458, Kansas City, Missouri 64141

APPLICATION FOR GROUP INSURANCE

1. Full Legal Name Of Applicant

2. Street Address	City	State	Zip Code

3. Nature Of Business

☐ Corporation ☐ Proprietorship ☐ Partnership ☐ Other ____________

4. The following ☐ Subsidiaries, ☐ Affiliated Companies, or ☐ Divisions are eligible for coverage:

Name: ____________ Name: ____________

Address: ____________ Address: ____________
Street Street

City State Zip Code City State Zip Code

(Please use a separate sheet of paper if additional space is needed.)

Will any Subsidiaries, Affiliates, or Divisions be excluded? ☐ No ☐ Yes Name: ____________

5. Number of individuals initially eligible to participate: ________

Number of individuals initially enrolled: ________

6. Are any individuals (including dependents) now disabled?
☐ Yes (Give details on separate page. Please include the person's name and a description of the disability.)
☐ No

7. The insurance being applied for ☐ replaces ☐ is in addition to the group insurance:

Name of Insurer	Coverage	Paid to Date

Name of Insurer	Coverage	Paid to Date

8. Are any individuals (including dependents) being continued under any state or federal Continuation of Coverage Provision?
☐ No
☐ Yes (Give the following details on a separate page: Name; Was the person an employee or a dependent; Age; Address; Is this a state or federal continuation; and number of months coverage has been continued to date.)

9. Amount of Advance Payment $ ____________

10. Employer Tax ID Number: ____________

11. Requested Effective Date: ____________

12. Indicate below the coverages applied for and the portion of premium paid by employer:

	Premium % Paid by Employer for Enrollees	Coverage Desired for Enrollees	Premium % Paid by Employer for Dependents	Coverage Desired for Dependents
Basic Life	______	☐	______	☐
Supplemental Basic Life	______	☐	______	☐
Basic AD&D	______	☐		
Supplemental Basic AD&D	______	☐		
Short Term Disability	______	☐		
Long Term Disability	______	☐		
Dental	______	☐	______	☐
Voluntary Life	______	☐	______	☐
Voluntary AD&D	______	☐		
Voluntary STD	______	☐		
Core Buy-Up Life	100% Core/0% Buy-Up	☐	______	☐
Core Buy-Up STD	100% Core/0% Buy-Up	☐		
Other:				
______	______	☐	______	☐
______	______	☐	______	☐
______	______	☐	______	☐
______	______	☐	______	☐

NOTE: ☐ The following coverage(s) are offered within a Section 125 plan: ______________________

☐ Premiums are on a Post-tax basis for the following coverage(s): ______________________

It is agreed that the group insurance, subject to the terms and conditions of the policies applied for will take effect as of the effective date requested, provided that this application is approved at the Home Office of BMA and provided that if the enrollees are to contribute to the cost of the insurance, insurance shall not become effective unless a minimum of eligible individuals have enrolled. If this application is not approved, no insurance shall become effective and any advance payment will be refunded. Approval of this application is not guaranteed. The employer should not cancel any other coverage until notified by BMA that this application is approved.

NO AGENT OR BROKER IS AUTHORIZED TO BIND COVERAGE, APPROVE APPLICATIONS, MODIFY POLICIES OR ALTER OR WAIVE ANY RIGHTS OR REQUIREMENTS OF BMA.

Signed at ______________, this ________ day of ______________, 19 ____

______________________ Agent or Broker Representing BMA

__________ Code

______________________ Full Legal Name of Applicant

By ______________________ Authorized Signature

______________ Title