USAble Life

SOLD CASE CHECKLIST

Submission of New Group Business

GROUP APPLICATION

____ Eligibility.

____ Waiting period.

____ Minimum hours worked.

____ Class descriptions.

____ Effective date of changes.

____ Effective date agreed to by carrier.

____ Rate guaranteed __ years, Which LOB's?

____ Signed by group leader (prior to effective date).

____ Contributory (Please provide percentage).

____ Replacement. Yes or no?

____ Tax ID number.

____ SIC code.

____ Master Application matches proposal.

____ Every field completed, even if not applicable.

____ FICA Match Agreement, if sold (STD, LTD)
Note: Not applicable for STD if FICA Match Agreement sent. Request for FICA Match with LTD must be made on remarks section of the Master Application.

____ STD: FICA Match Agreement (if sold).

____ STD: W2 Agreement (n/a if FICA Match Agreement sent).

____ LTD: W2 election must be made on the Master Application.

____ LTD: FICA Match (if sold) request in remarks on Master Application.

CENSUS ENROLLMENT

____ Completed NTake Census File (Automated; Faster Processing).

____ Name.

____ Date of birth.

____ Gender.

____ Social Security Number.

____ Date of hire.

____ Voluntary benefits (spouse info and coverage amount).

____ Annual earnings (STD, LTD, or salary based life benefits).

____ Insurance class.

____ Hours worked per week.

____ Employer name and location if applicable.

____ LTD census must include occupation.

Note: If self-administering, group may submit census showing above information. Enrollment Forms must be maintained by group for claim purposes.

EVIDENCE OF INSURABILITY FORMS (if needed)

____ Employee must complete and sign if benefit exceeds guarantee issue limit specified in proposal.

VOLUNTARY INFORMATION (required)

____ Commission Distribution Form.

____ Applications, for all participants, if NTake Census File not used (Manual Processing; Slower Turnaround)

ADDITIONAL COMMENTS

____ Include commission distribution sheet.

____ Include copy of current carrier booklet.

____ Pre-ex requirements.

REQUIREMENTS FOR GRANDFATHERING/TAKEOVER

____ Copy of prior carrier policy.

____ Grandfathered employees census or prior carrier bill that includes name, Social Security Number, date of birth, coverage with prior carrier.

____ Obtain Underwriting approval for Grandfathered amounts.

____ Voluntary benefits (spouse info and coverage amount).

NOT ACTIVELY AT WORK LIST (sick leave/disabled)

Attach a list of employees not actively at work due to sickness or disability.

____ Name.

____ Gender.

____ Date sickness or disability began.

____ Anticipated return-to-work date.

____ Face amount of benefits.

____ Include copy of most recent bill (if replacing prior coverage).

____ Hours worked per week.

Note: If self-administering, group may submit census showing above information. Enrollment Forms must be maintained by group for claim purposes.

USAble Life
P.O. Box 1650
Little Rock, Arkansas 72203

GROUP INSURANCE APPLICATION

For Home Office use only
Group #:

SECTION I. GROUP INFORMATION

1. Legal Name of Policyholder | 2. Taxpayer ID#

3. Type of Company: ☐ Corporation ☐ LLC ☐ PC ☐ S-Corp ☐ Sole Proprietor ☐ Partnership ☐ Government

4. Mailing Address of Policyholder | City | State | Zip+4

5. Street Address of Policyholder (if different from above) | City | State | Zip+4

6. Contact Information at Company:
Benefits Contact Person: ______
Phone Number: ______ Fax Number: ______
Email Address: ______ Web Address: ______
Billing Contact Person: ______
Phone Number: ______ Fax Number: ______
Email Address: ______ Web Address: ______

7. Name of Subsidiary or Affiliate Companies to be Covered | 8. Nature of Business | 9. SIC Code

10. Do you have any employees located in states other than the Policyholder's main address? If yes, please list states below. ☐ Yes ☐ No

11. Number of eligible Employees

12. Billing Method: ☐ Self Administration ☐ Billed by Blue Plan ☐ Benefit Focus ☐ List Bill

13. Changes in Benefits will Become Effective on:
☐ First day of the following month ☐ The next anniversary date ☐ The date of change

14. Do you allow Domestic Partner Coverage under the existing Blue Cross Blue Shield Medical Plan? ☐ Yes ☐ No

15. Eligibility Waiting Period *(Should an employee enter another class, he will not be eligible for any additional benefits until he has completed a 30-day waiting period and has been actively at work one full day in the new class.)*
☐ First of Policy Month following: (a) ☐ completion of ________days of continuous active work, or (b) ☐ hire date
☐ Day following: (a) ☐ completion of _________days of continuous active work, or (b) ☐ hire date
Does Waiting Period apply to employees rehired within 12 months of their termination date? ☐ Yes ☐ No

16. Eligibility Waiting Period Applies to:
☐ Future Employees only ☐ Present & Future Employees

17. Minimum hours worked per week to be eligible:
Basic benefits: _________ Voluntary benefits: _________

18. Annual Enrollment date for Voluntary Coverage: ____________________

19. Class Definitions (if more than one class, definitions must be specific)
(The insurer reserves the right to review and terminate all classes insured under this policy if any class ceases to be covered.)

Class	Description of Class	Waiting Period, if Different
1		
2		
3		
4		

Employees working less than the minimum hours per week are not eligible for coverage unless otherwise noted in class description above and approved by us. If more than four classes, use a separate sheet.

SECTION II. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
☐ Basic Life				
☐ Basic AD&D*				
☐ Supplemental Life*				
☐ Supplemental AD&D*				
☐ Dependent Life* (Option 1)				
☐ Dependent Life* (Option 2)				
☐ Voluntary Life				
☐ Voluntary AD&D				

Cannot be purchased as stand alone coverage.

Multiple of salary benefits will be rounded to the ☐ nearest ☐ lower ☐ higher $____________, if not already a multiple

Legal Name of Policyholder	Taxpayer ID#

SECTION II. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT CONTINUED

Basic Life and/or AD&D

Class	Flat Amount ■	Multiple of Salary ■	(Complete if Multiple of Salary)	
			Min Amount of Coverage	Max Amount of Coverage
1				
2				
3				
4				

Supplemental Life and/or AD&D

Class	Flat Amount ■	Multiple of Salary ■	Elected in Increments of ■	(Complete if Multiple of Salary or Increments)	
				Min Amount of Coverage	Max Amount of Coverage
1					
2					
3					
4					

Voluntary Life and/or AD&D

☐ Employee and Spouse coverage elected in $10,000 increments: $10,000 min $__________ Max

☐ Employee coverage elected as multiple of salary schedule: __________ times annual salary $__________ Maximum.
Spouse coverage 50% of employee amount.

Are Voluntary Life rates smoker distinct rates: ☐ Yes ☐ No Children - $5,000 and $10,000 only

Dependent Life

Class	Option 1			Option 2 (if available)		
	Spouse Amount	Child Amount	Reduced Infant Amount	Spouse Amount	Child Amount	Reduced Infant Amount
1						
2						
3						
4						

Infant Ages: ☐ from live birth to 6 months ☐ from 15 days to 6 months

Child Ages: ☐ 6 months to 25 years ☐ 6 months to age __________

AD&D Riders	
Standard Riders*	☒
Special Education	☐
Paralysis	☐
Common Carrier	☐
Felonious Assault	☐
Child Care Center	☐
Spouse Training	☐
HIV	☐
	☐

Reductions & Termination
Benefit reduction due to age will be effective on the employee's birthday*

	Reduction at Age of Employee			
	65	70	75	80
☐	66 2/3%	33 1/3%	N/A	N/A
☐	65%	50%	N/A	N/A
☐	65%	50%	25%	N/A
☐				

**Employee benefits terminate at retirement, unless termination age is noted. Termination age _________. Spouse benefits terminate at employee's retirement or spouse age 65, whichever is earlier. All reductions apply to the pre-age 65 amount.*

**AD&D Standard Riders:* Seat Belt/Air Bag, Coma, Repatriation, Exposure and Disappearance

Portability:
☐ Voluntary Life ☐ Basic Life (Underwriting approval and rate adjustment required)

Replacement: Are any of the following a replacement of similar coverage?

Yes	No		If yes, Previous Carrier	Termination Date
☐	☐	Basic Life		
☐	☐	Supplemental Life		
☐	☐	Voluntary Life		

If prior coverage, include a copy of the prior carrier's plan.

SECTION III. SHORT TERM DISABILITY

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
☐ Basic/Core STD				
☐ Buy Up STD*				
☐ Voluntary STD (VIP)				

**Cannot be purchased as stand alone coverage.*

Legal Name of Policyholder	Taxpayer ID#

SECTION III. SHORT TERM DISABILITY CONTINUED

Basic Short Term Disability

Class	Core/Buy Up	■ Flat Amount	■ Percent of Salary	Max. benefit	Benefit Plan*
1	☐ Core				
	☐ Buy Up				
2	☐ Core				
	☐ Buy Up				
3	☐ Core				
	☐ Buy Up				
4	☐ Core				
	☐ Buy Up				

**Example of a Benefit Plan: 1-8-13; This means disabilities due to accidents begin on the first day. Disabilities due to sickness begin on the eighth day. Benefits will be paid for a 13 week duration.*

Voluntary STD Income Protection (VIP)

Amount of insurance selected by the employee in increments of $10 not to exceed _____% of weekly earnings.

Minimum: $100 Maximum: ☐ $750 ☐ _______________

Benefit Plan*: _______________ Industry Class: _______________

Reduction & Termination: Benefit reduction due to age will be effective on the anniversary following the insured's birthday. Benefits reduce to 66 2/3% at age 65, and terminate at age 70 or upon retirement, whichever occurs first.

Are premiums sheltered under a Section 125 Cafeteria plan? ☐ Yes ☐ No

**Example of a Benefit Plan: 1-8-13; This means disabilities due to accidents begin on the first day. Disabilities due to sickness begin on the eighth day. Benefits will be paid for a 13 week duration*

Replacement: Is VIP a Replacement from Another Carrier? ☐ Yes ☐ No

Previous Carrier ____ Termination Date _______________

If prior coverage, include a copy of the prior carrier's plan.

SECTION IV. LONG TERM DISABILITY

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
☐ Basic LTD				
☐ Buy Up LTD*				
☐ Voluntary LTD				

**Cannot be purchased as stand alone coverage.*

Basic and Buy Up Features

Class	Elimination Period	Own Occupation Monthly Period	Salary Includes		SS Integration		Benefit Calculation	
			Bonuses	Commissions	Primary Only	Primary/ Family	Direct	70% all Sources
1			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes
3			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes
4			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes

Class	Basic		Buy Up	
	% of Salary	Monthly Max	% of Salary	Monthly Max
1				
2				
3				
4				

Maximum Benefit Period	Class			
	1	2	3	4
Reducing Benefit Duration	☐	☐	☐	☐
SS Normal Retirement Age (SSNRA)	☐	☐	☐	☐
2 Year benefit (ADEA)	☐	☐	☐	☐
3 Year benefit (ADEA)	☐	☐	☐	☐
5 Year benefit (ADEA)	☐	☐	☐	☐

Minimum Monthly Benefit

☐ Flat amount $ _______________; or ☐ Flat amount of $ _______________ or 10%, whichever is greater

Optional LTD Riders

☐ Education Benefit
☐ Activities of Daily Living
☐ Medical and COBRA Premium $ ___________
☐ Accidental Dismemberment
☐ Cost of Living Adjustment
_____# of Adjustments _____%

Legal Name of Policyholder	Taxpayer ID#

SECTION IV. LONG TERM DISABILITY CONTINUED

Disability Definition: ☐ Earnings & Occupation Test ☐ Occupation Test Only
☐ Earnings, Occupation, and Contagious Disease (Only available for Medical Groups)

Pre-Existing Condition Exclusion
☐ 3/3/12 ☐ 3/6/12 ☐ 12/6/24 ☐ 6/12 ☐ 6/6/12 ☐ 12/12 ☐ _______

Voluntary Long Term Disability (VLTD)
Industry Class: _____________ Elimination Period: ☐ 90 Days ☐ 180 Days

Maximum Benefit Period:
☐ 2 years Sickness or Accident ☐ 5 years Sickness or Accident ☐ SSNRA Sickness or Accident

a. Amount of Insurance: Selected by the employee in increments of $100 not to exceed 60% of monthly salary.
b. Pre-existing Condition Exclusion: 12/6/24 (unless state law requires otherwise)
c. The Minimum Monthly Benefit is $ 50.00 or 10% of the Monthly Disability Benefit, whichever is less (unless state law requires otherwise)
d. Policy Features include: • 24 Month Own Occupation • Three month Survivor Benefit • Waiver of Premium • 24 Month Special Conditions Limitation • Primary and Family Social Security Integration
e. Are premiums sheltered under a Section 125 Cafeteria plan? ☐ Yes ☐ No

Replacement: Are any of the following a replacement of similar coverage?

Yes	No		If yes, Previous Carrier	Termination Date
☐	☐	LTD		
☐	☐	VLTD		

If prior coverage, include a copy of the prior carrier's plan.

W-2 Service Options for LTD:

☐ Option 1: Withhold federal income taxes and the employee's portion of FICA. Prepare and file W-2 Forms.

☐ Option 2: Withhold federal income taxes and the employee's portion of FICA. Policyholder waives W-2 Forms services.

A detailed description of the W-2 services elected by policyholder pursuant to this application will be sent to the policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.

SECTION V. AUTHORIZATION

REMARKS OR SPECIAL PROVISIONS:

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through USAble Life and agrees to comply with all terms and provisions of the Group Policy(ies) issued in response to this application.

It is understood and agreed that this application shall be made a part of the policy or policies applied for and that no insurance shall be effective until approved by the Company at its Home Office.

Warning: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines or a denial of insurance benefits in accordance with applicable state law.

______________________	______________	______________________
Dated at (City, State)	Date	Signature of Policyholder and Title
______________________	______________________	______________________
Signature of Marketing Representative	Signature of Marketing Manager	Signature of Broker, if applicable

Submit form via email, fax, or mail:
New Group: NewBusiness@usablelife.com; or,
Change Existing Group: Amendents@usablelife.com
FAX: 501-235-8419
Mail: PO Box 1650
Little Rock, AR 72203-1650

Short Term Disability W-2 Agreement

Effective Tax Year of Request *(applies to current and future tax years):* **Tax year ending December 31, 20_________**

Employer Name: ____ **Group Number:** ______________________

Contact Person: ____ **Title:** ____________________________________

Contact Email: ____ **Phone Number:** _______________________

Per IRS Regulations, Forms W-2 are filed to report short term disability benefits paid to employees. Both taxable and nontaxable benefits are reported. The employee contributions made with after tax dollars will determine what portion of sick pay, if any, is excludable from employee's gross income. **Employer is responsible for providing the information necessary to determine the taxable portion of sick pay.** Employer can prepare the W-2's or elect USAble Life to prepare them. Please read the information below then select who will be responsible for W-2 reporting.

- ***This agreement is for short term disability benefits only. It does not apply to long term disability.***
- If you use an external payroll vendor, please contact the vendor prior to electing USAble Life to prepare W-2's. Most vendors require that they prepare the forms.
- If you select USAble Life to prepare the W-2's, you are to file a summary W-2 to reconcile the difference between your Forms 941 and your W-2's. See IRS Publication 15-A at www.irs.gov..
- USAble Life will withhold and deposit employee Social Security and Medicare taxes (FICA taxes) and federal income tax if requested by the employee. USAble Life will notify Employer of the taxable benefits paid.
- Under no circumstance is USAble Life responsible for Employer's portion of FICA taxes, FUTA taxes, any other payroll or employment related tax, fee, premium or the like, including state disability insurance, state or local occupational tax or any Worker's Compensation tax which may be applicable to sick pay.
- **November 30th is the last date** for changing the W-2 Option selected for the tax year. This Agreement will continue until replaced by a new agreement, the Policy terminates and/or sick pay payments are discontinued.

☐ **OPTION 1 - USAble Life DOES prepare W-2 statements reporting STD benefits for payees.**
Employer hereby designates USAble Life as its agent for the sole purpose of providing W-2 statements with sick pay information to payees by January 31st of each year, or such other date required by the IRS. USAble Life will use its name and EIN on each of these forms. If Policy terminates, USAble Life will continue to provide W-2'S for sick pay payments on all claims incurred prior to termination of policy.

☐ **OPTION 2 - USAble Life DOES NOT prepare W-2 statements reporting STD benefits for payees.**
If this option is chosen, USAble Life will provide Employer, by January 15th of each year, with the information required by Federal law for Employer to prepare W-2's for its employees and file Federal and State information returns.

EMPLOYER

Signature:____

Title:____

Date:____

USABLE LIFE

Signature: ____

Title:____

Date: ____