

Request for Group Insurance

The CORE and MORE Plan



GENERAL INFORMATION:

Employer Name: _____	Industry: _____
Address: _____	SIC Code: _____
City: _____	State: _____ Zip: _____
Contact Name: _____	Title/Dept: _____
Address (if different): _____	
City: _____	State: _____ Zip: _____
Phone #: _____	Fax #: _____
Email: _____	
Will eligibility extend to employees of Subsidiaries or Affiliates? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please list the Subsidiaries or Affiliates: _____	
Does the Employer have a DBA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, provide name(s): _____	
Is this Policy replacing existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please describe: _____	
Payroll Cycle: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Bi-monthly <input type="checkbox"/> Monthly	

PLAN:

Select CORE and MORE Plan
<input type="checkbox"/> CORE and MORE Please attach Rating Worksheet
Add Ancillary Coverages
<input type="checkbox"/> CORE and MORE Ancillary Package

SUBSIDY:

CORE and MORE
* If the "Employee Only" Medical Premium is greater than \$25.00, then employer subsidy is required:
Medical Subsidy: <input type="checkbox"/> \$ _____
Ancillary Package Subsidy: <input type="checkbox"/> \$ _____ <input type="checkbox"/> % _____
* Subsidy amount is then applied to all Medical coverage levels: EE Only, EE + 1, and EE + Family

ELIGIBILITY:

Number of Eligible Employees: _____	Eligibility Waiting Period (if any): _____
Average Eligible Employee Age: _____	
Definition of Eligible Employee: _____	
Requested Policy Effective Date: _____	(Minimum 90-day notice required)

ERISA INFORMATION: (In order to prepare SPD)

*Plan Sponsor, if different from Employer: _____	Fed Tax ID #: _____
*Plan Administrator, if different from Plan Sponsor: _____	Title: _____
Plan Name: _____	Plan Number: _____
Plan Fiscal Year End: _____	Agent for Service: _____
*If Plan Sponsor or Plan Administrator's Address is different from the Client's Address, please list below:	
Address: _____	
City: _____	State: _____ Zip: _____

MATERIALS:

- Should we incorporate the Employer Logo? Yes No
If Yes, how will you provide it to us: Electronic Hard-copy
Will the Employer print the materials? Yes No

If No, please provide shipping instructions if different from contact info.

Ship to the attention of: _____ Title/Dept: _____
Address (if different): _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____
Email: _____

If shipping to multiple locations, please use a separate sheet.

AGENT/BROKER INFORMATION:

Name: _____ Email: _____
Phone #: _____ Fax #: _____

Are you affiliated with a firm? Yes No If Yes, firm's license #: _____

Send policy forms to: Me Policyholder Other

If this is your first sale of a ValuBenefits Product, please attach a copy of your resident license when submitting this form.

EMPLOYER CERTIFICATION:

The employer hereby agrees to the following:

1. We are requesting that Stonebridge Life Insurance Company prepare the necessary materials so that a limited benefit medical plan may be offered to our eligible employees.
2. We understand that policy forms will be prepared separately, including a Group Application which we must sign and return upon delivery, and that the insurance will not go into effect until first premium is received.
3. We have reviewed the sales material which, taken together, describes the coverage terms, conditions, limitations and exclusions of the plans for which we are requesting enrollment. These plans have been explained in full by the Stonebridge Life Insurance broker/agent whose signature appears below. We understand the coverage terms, conditions, limitations and exclusions of the plans for which we are requesting enrollment.
4. All of the information provided on this request is correct, to the best of our knowledge.

Employer Authorized Signature: _____ Title: _____ Date: _____

Broker or Agent Signature: _____ Date: _____