

Request for Group Insurance

The ValuMed 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"/> Semi-monthly <input type="checkbox"/> Monthly	

PLAN SELECTION:

Select ValuMed Plan	OR	Select ValuMed Plan – Series II
<input type="checkbox"/> ValuMed Plan 1		<input type="checkbox"/> Series II – Option 1
<input type="checkbox"/> ValuMed Plan 2		<input type="checkbox"/> Series II – Option 2
<input type="checkbox"/> ValuMed Plan 3		<input type="checkbox"/> Series II – Option 3
		<input type="checkbox"/> Series II – Option 4
Add Ancillary Coverages		
ValuMed Ancillary Options:		
<input type="checkbox"/> Dental Plan		<input type="checkbox"/> TermLife/STD

SUBSIDY:

ValuMed		
Employer Subsidy:	<input type="checkbox"/> \$ _____	<input type="checkbox"/> % _____
Subsidy Applies to:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental <input type="checkbox"/> Term Life/STD*
Subsidy Applies to:	<input type="checkbox"/> EE Only	<input type="checkbox"/> EE and Dependent Coverage*
*Short-Term Disability coverage is not available for dependents (Employee Only)		

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 voluntary program of insurance 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 Company 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. We understand that implementation of the Stonebridge Life Insurance Company program is dependent on our ability to provide basic employee data to the administrator. We further understand that, within one month of the signature date below, we must provide this data to the administrator on a test basis. If the administrator is unable to accept this data, we understand that the program may be delayed or may not be implemented.
5. 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: _____

