The Hartford

New Case Submission Checklist

Groups with 4-9 Eligible Lives

Ohio

- ☐ Participating Employer Agreement
  - ***Employer*** *signature required*
  - ***Broker*** *signature required*
- ☐ Sold Case Kit
- ☐ Enrolled Census
- ☐ W-2 and FICA Match Service Agreement **(when STD or LTD is sold)**
  - STD Tax Service Agreement *(**Employer** signature required)*
  - LTD Tax Service Agreement *(**Employer** signature required)*
- ☐ Sold Proposal (only the pages that sold)

NO BINDER CHECK IS NEEDED

Aspire Benefit Services
6099 Riverside Dr., Suite 104 | Dublin, Ohio 43017 | P 614.874.0472 | F 614.874.0474
quotes@aspirebenefits.com

SMALL BUSINESS PARTICIPATING EMPLOYER AGREEMENT

By completing this Small Business Participating Employer Agreement (*the "Agreement"*), the Proposed Participating Employer ("*Employer," "You"* or "*Your"*) named below requests participation in the Group Benefits Insurance Trust for Employers in General Services Industries ("*Trust"*) for insurance coverage issued under one or more insurance policies ("*Policy"* or "*Policies"*) issued to the Manufacturers and Traders Trust Company, located at 1350 I Street, NW, Suite 200, Washington, DC 20005, as Trustee. The Policies are issued by Hartford Life and Accident Insurance Company ("*We", "Our",* or *"Us"*).

CUSTOMER NUMBER(S):

EMPLOYER INFORMATION: Enter information exactly as it should appear in the certificate.

Full legal name of Employer:

Address: *Street and number*

City *State* *Zip* *County*

Contact: ☐ **Mr.** ☐ **Ms.** *Last* *First*

Phone: **Fax:**

Federal Tax ID Number:

E-mail:

Coverage Requested:

The proposed insurance coverage(s) is/are those You elected in the *Proposal of Employee Benefits* (the "Proposal").

SIGNATURES

By signing below, You understand and agree that:

1) The insurance coverages You are requesting and the initial rates and rate guarantees are as stated in the Proposal.
2) This Agreement is subject to the terms of the Trust. Insurance coverage, if issued, is subject in every respect to the terms of the Policies, which alone constitute the contracts under which benefits are paid. The Policies are available for review upon request.
3) To determine whether You qualify for coverage, We will look at the information You have provided to Us. We will not put any insurance coverage(s) into force under any of the Policies if You do not satisfy the requirements of the Trust for becoming a Participating Employer or if You do not qualify for coverage based on our established underwriting criteria.
4) If You satisfy the requirements of the Trust for becoming a Participating Employer and if We agree to put coverage into force for You under the Policies, We will issue certificates of insurance as evidence of Your employees' coverage under the applicable Policies. In no event will any insurance coverage take effect until the latest of the following: (i) the date the first premium is received; (ii) the *Requested Effective Date of Coverage* stated below; or (iii) the date We agree to put coverage into force pursuant to this Agreement, the Policies and Our underwriting rules. We will return any premium We have accepted if coverage cannot be put into force for any reason.
5) Once Your coverage under a Policy is in force, Your coverage will terminate if:
   a) You cease to be a participating employer of the Trust;
   b) The Policy terminates; or
   c) Your premium is due but not paid, subject to the grace period.

   In addition, Your coverage may terminate if:
   a) You fail to perform any of Your obligations pertaining to the Policy;
   b) Less than 100% of Your employees eligible for coverage under Your employer-paid plan are insured;
   c) Less than 75% of Your employees eligible for coverage under Your employee-paid voluntary plan are insured; or
   d) Fewer than 4 of Your employees are insured under the Policy.

   If We terminate Your coverage under a Policy for reasons other than Your failure to pay premium, a written notice will be delivered to You at least 31 days prior to the termination date. We allow a grace period for payment of all premiums after the first. During this 31-day period, Your coverage under the Policy stays in force. If the owed premium is not paid by the 31st day, Your coverage under the Policy will automatically terminate. If You give Us written advance notice of an earlier cancellation, Your coverage under the Policy will terminate on the earlier date. Premium is due for each day the Policy is in force.

Requested Effective Date of Coverage:

Dated at **this** **day of** **, 20** **.**

Witness: _____
Licensed Resident Agent

Employer: _____

California/Florida Only: _____
Agent'sLicense/Identification number

By: _____
Signature *Title*

STATE NOTICES

All states except CO, FL, NJ, and VA: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer file a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

VA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Additional notice for NC: Under North Carolina General Statute section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance, or health care plan premiums, will: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service plan, multiple employer welfare arrangement, or health care plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay such premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days prior to the termination of such coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

Group Benefits Disclosure Notice

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions regarding your insurance producer's compensation directly to your insurance producer.

The Hartford Small Business Solutions Sold Case Summary

To facilitate the timely processing of your policy, please ensure that all information is complete and accurate - and received at The Hartford by the 7th calendar day of the effective month of coverage.

SECTION 1 **PLAN COVERAGE** (Check all that apply & provide prior carrier name)			
Plan:	**Prior Carrier:**	**Plan :**	**Prior Carrier:**
☐ Basic Life		☐ Supplemental (Voluntary) Accidental Death & Dismemberment	
☐ Accidental Death & Dismemberment		☐ Short Term Disability	
☐ Basic Dependent Life		☐ Long Term Disability	
☐ Supplemental (Voluntary) Life		☐ Critical Illness	
☐ Supplemental (Voluntary) Dependent Life		☐ Accident	
		☐ Hospital Indemnity	

SECTION 2 **POLICYHOLDER INFORMATION** (Provide missing or adjust incorrect information)	
Legal Name (as it should appear on all legal contract documents):	
Legal Address (*cannot* be a P.O. Box):	
City, State, Zip Code:	
Plan Administrator Contact Name/Title:	**Telephone Number:**
E–mail address:	**Fax Number:**
Billing Contact Name/Title:	**Telephone Number**
E-mail address:	**Fax Number:**
Billing Street Address 1: (☐ Same as above)	
City, State, Zip:	**Situs State:**
Number of Eligible Employees:	**Plan Effective Date:**
Client's SIC Code:	**Federal Tax ID:**
Client's Nature of Business:	**Number of Years in Business:**

The Hartford Small Business Solutions Sold Case Summary

SECTION 3	ADDITIONAL POLICYHOLDER INFORMATION

TYPE OF LEGAL ENTITY (please check one)

☐ Corporation ☐ S Corporation ☐ Partnership ☐ Non-Profit Organization
☐ Sole Proprietor ☐ Limited Partnership ☐ LLC ☐ Proprietorship

SECTION 4	ENROLLED CENSUS INFORMATION

Please provide the following enrolled census information. Please submit this data in an EXCEL format that can be e-mailed or mailed on disk. All information under # 2 below is required for Critical Illness, Accident and Hospital Indemnity coverage.

1) Employee information

- First Name
- Last Name
- Date of Birth (mm/dd/yyyy)
- Date of Hire (mm/dd/yyyy)
- Employee ID
- Earnings or Coverage Amount (if coverage amount based on earnings)
- Gender
- Work Zip Code
- Employee Full Address (Note: Only required for Critical Illness, Accident and Hospital Indemnity)

2) Supplemental (Voluntary) Dependent, Critical Illness, Accident and Hospital Indemnity Information

- Spouse Name (preferred, but not required)
- Spouse Date of Birth (preferred, but not required)
- Child(ren) Name(s) (preferred, but not required)
- Child(ren) Date(s) of Birth (preferred, but not required)
- Tobacco User Status (not needed for Accident and Hospital Indemnity coverage)

3) Supplemental (Voluntary) Life Elections broken out by Employee, Spouse, Child

- Prior carrier inforce amounts are required in addition to Hartford Supplemental Life Elections

4) For Accident and Hospital Indemnity, indicate plan election as low, mid or high. (Reference proposal for details specific to your group)

SECTION 5	ENROLLMENT INFORMATION

1) Do you have voluntary coverage Yes ☐ No ☐ *If yes, please provide details below. If no, move to section 6.*

2) Did you hold an initial enrollment? Yes ☐ No ☐

If yes, please provide the dates of the initial enrollment From: _____ To: _____

Note: The Initial enrollment dates are the date the employees are initially able to enroll in the Voluntary coverage with The Hartford.

SECTION 6	DOMESTIC PARTNER COVERAGE

1) Are there any employees LIVING in states other than the situs state of the Employer?

If Yes, please indicate states, and the number of employees in each state:

2) Other than as required by law, include Life insurance coverage for Domestic Partners? Yes ☐ No ☐

Note: Domestic Partners will need to complete a Hartford affidavit if they do not reside in a state that has a Domestic Partner registration process. If your company's situs state (legal address) is in Louisiana, Kansas and Virginia, Domestic Partner coverage is not available.

Domestic Partner Coverage is also not available for residents of Louisiana.

SECTION 7 BILLING DELIVERY INFORMATION

Your billing information is available automatically on our on-line site EmployerView.com

We will establish your bill through our E-Bill Program via our EmployerView.com website.Your monthly email bill notice provides immediate access to secure billing, the ability to view and print actual invoices online (if desired) to save time, and ensures accuracy. You can make your payments via this website (ACH Debit, AutoPay) or send in a check. EmployerView.com allows you to make administrative changes (new hires, terminations, salary changes, etc) and access other plan materials.

Note: *For any Critical Illness, Accident and Hospital Indemnity coverages, billing changes cannot be processed on EmployerView.com at this time.*

Please contact us with any questions.

SECTION 8 BOOKLET/ADMINISTRATION MANUAL DELIVERY INFORMATION

Your employee booklets and Administration manual will be emailed to you and are available automatically on our on-line site EmployerView.com

Please contact us with any questions.

SECTION 9 POLICY PROVISIONS (Please check one for each coverage)

Original Employee Waiting Period: On the policy effective date

New Employee Waiting Period:

LIFE	☐ 0 days	☐ 30 days	☐ 60 days	☐ 90 days	☐ 180 days
LIFE and ADD	☐ 0 days	☐ 30 days	☐ 60 days	☐ 90 days	☐ 180 days

Safe Haven Program

Employer elects to offer Employees' Beneficiaries the option of receiving proceeds via:

☐ Safe Haven Program or Lump Sum Check
☒ Lump Sum Check only

SECTION 10 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) (CONFORMING INSTRUMENT INFORMATION)

Please provide / confirm the following information. These will appear in the booklet:

The Hartford Small Business Solutions Sold Case Summary

Note*- All groups are subject to the Employee Retirement Income Security Act of 1974 ("ERISA") with the exception of the following legal entities: Municipalities/Governments, Public Schools, Church or Government related Non Profit/Charitable organizations, Religious Groups, Sovereign Nations, State Universities. The Hartford is required to provide ERISA Plan information in the booklet. If the group does not have a plan number assigned or filed with the Department of Labor, ERISA Plan number 501 will be used.*
Plan Name:
Plan Number:
Employee / Plan Sponsor:
Plan Administrator:
Agent for service of legal process for the Plan:
Source of Contributions: The Employer pays the premium for insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid to by the employee.
Type of Administration: The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan.
Plan Records: The Plan and its fiscal records are kept on a Policy Year basis.
Type of Plan: Welfare Benefit Plan providing Group benefits.

SECTION 11	**EARNINGS DEFINITION**	
☐ Salary only	☐ Salary & commissions *	☐ W-2 and K1 **

* Earnings definition contains a 12-month average of commissions.

** All S-Corps must select this option as an earnings definition - no exceptions. Definition contains a 2 calendar-year average of earnings.

SECTION 12	**AGENCY INFORMATION**
Agency Name:	**Sub-Producer Name:**
Agency Address:	**Agency Phone Number:**
Renewal/Ongoing Service Contact First and Last Name:	**Renewal/Ongoing Service Contact Email:**

Tax Service Agreement
Short Term Disability (STD)

POLICYHOLDER/EMPLOYER NAME: _____

EFFECTIVE DATE OF REQUEST (current or future date only): _____

By completing the following agreement, you authorize The Hartford* to report, withhold and deposit the taxes described below.

A. **STANDARD TAX SERVICES**

- The Hartford will withhold and deposit applicable and properly elected additional United States federal income taxes (FIT) and state income tax (SIT) as well as applicable Employee FICA taxes from disability benefits/sick pay. The Hartford will make timely filings with the appropriate United States federal and state agencies.
- The Hartford will deposit the taxes using The Hartford's tax identification number and will timely notify Policyholder/Employer of these payments. This notification is provided to you on the EOB (Explanation of Benefits).
- The Hartford assumes no responsibility for the Policyholder/Employer's share of FICA (unless elected below).
- The Hartford assumes no responsibility for any other payroll or employment related tax, fee, premium or the like including Federal Unemployment Insurance (FUTA) and State Unemployment Insurance (SUTA), State Disability Insurance, State or Local Occupational Taxes, other jurisdictional taxes such as municipal, city or county taxes, or any Workers' Compensation Tax which may be applicable to the disability benefits The Hartford is paying.
- The Hartford will prepare and deliver to Policyholder/Employer the annual summary reports of benefits paid.

B. **W-2 SERVICES (select one)**

☐ Policyholder/Employer **authorizes** The Hartford to prepare Forms W-2 for payees and file such forms with the appropriate United States federal and state agencies.

- The Hartford will postmark by January 31st of each year, or such other date required by law, Forms W-2 containing sick pay information to payees and make information return filings in accordance with Federal and State requirements regarding income tax, Social Security, and Medicare tax.
- The Hartford will issue Forms W-2 using The Hartford's tax identification number.
- If the Policy is terminated, The Hartford will continue to provide Forms W-2 and make information return filings for disability benefits/sick pay payments on all claims incurred prior to termination of the Policy.

☐ Policyholder/Employer **declines** The Hartford service to prepare Forms W-2 for payees or file Federal and State information returns reporting disability benefits/sick pay. The Hartford will provide Policyholder/Employer by January 15th of each year the information required by Federal law to enable Policyholder/Employer to prepare Forms W-2 for its active and terminated employees.

If Policyholder/Employer declines W-2 services, FICA Match Service may not be selected below.

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C. **FICA MATCH SERVICE (W-2 Services must be selected above if Policyholder/Employer authorizes FICA Match Services.)**

Policyholder/Employer **authorizes** The Hartford to prepare Forms W-2 as selected in section B, and to pay Policyholder/Employer's share of FICA taxes (FICA Match Service). Policyholder agrees that adding STD FICA Match Service will require underwriter review. If selection of this service results in a change in monthly premium or fees, Hartford will promptly notify Policyholder/Employer. This authorization applies to the following plan(s):

☐ Fully Insured STD (Not available to some case sizes)

☐ New York Statutory (DBL)

☐ New Jersey Statutory (TDB)

☐ Hawaii (TDI)

☐ Administrative Services Only (ASO) STD

- Employer agrees to fund an imprest account by remitting to The Hartford an amount equal to one month of existing FICA Tax Liability to cover outlays of funds for the deposit of the Employer's portion of the FICA deposit prior to reimbursement.

  Amount submitted with this Agreement $

- The Hartford will prepare a monthly invoice itemizing the FICA taxes paid on Employer's behalf and that Employer will remit payment to The Hartford upon receipt of the invoice.

☐ California Statutory (CASDI)
(Note PFL is not subject to state or FICA tax)

Policyholder/Employer **declines** The Hartford's FICA Match Service and will report and deposit its share of any FICA tax withheld from benefits paid, if applicable. This declination applies to the following plan(s):

☐ Fully Insured STD

☐ New York Statutory (DBL)

☐ New Jersey Statutory (TDB)

☐ Hawaii (TDI)

☐ ASO STD

☐ California Statutory (CASDI)
(Note PFL is not subject to state or FICA tax)

D. **HOW TAX SERVICES APPLY TO POLICYHOLDER/EMPLOYER'S LOCATIONS, DIVISIONS, OR EMPLOYEE CLASSES**

Tax Services selected above apply to all locations, divisions and/or classes of the Policyholder/Employer.

☐ Yes ☐ No

If no, the Policyholder/Employer must provide The Hartford with a listing of all locations, divisions and/or classes that will have Tax Services that differ from the selections under Sections B and C of this agreement.

E. **GENERAL PROVISIONS**

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1. Changing Selected Tax Services

Policyholder/Employer agrees that any service change regarding Forms W-2 must be requested in writing on or before November 15th of the current tax year. Any change in W-2 Services after November 15th may result in Employees receiving Forms W-2 after January 31st or possible duplicate forms issued from both The Hartford and Policyholder/Employer.

Policyholder/Employer agrees that any service change regarding Employer FICA Match service will be effective on January 1st following the date on which a new Tax Service Agreement has been signed and submitted to The Hartford.

2. Accurate and Timely Information

Policyholder/Employer agrees to provide The Hartford with accurate and timely information to provide selected tax services, including information to determine the taxable portion of the benefits. Submission of incorrect taxable portion of benefits by the Policyholder/Employer which later requires The Hartford to retroactively correct claimant net benefits may result in fees payable to The Hartford to cover reasonable processing.

3. Hold Harmless

Policyholder/Employer agrees to indemnify and hold The Hartford harmless from any and all liability, including but not limited to fines or penalties that may result from erroneous, incomplete, or untimely information provided by Policyholder/Employer to The Hartford in connection with the selected tax services and The Hartford's performance of its duties under this Agreement.

4. Pricing for selected Tax Services

Policyholder agrees that the Fully Insured FICA Match Service will require underwriter review. If selection of this service results in a change in premium, Hartford will promptly notify Policyholder.

Employer agrees that the ASO W-2 AND FICA Match Services will require underwriter review. If selection of this service results in a change in fees, Hartford will promptly notify Employer.

Legal Name of Entity

_____ _____

Signature Date

Name and Title of Authorized Signer

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Tax Service Agreement
Long Term Disability (LTD)

POLICYHOLDER/EMPLOYER NAME: _____

EFFECTIVE DATE OF REQUEST (current or future date only): _____

By completing the following agreement, you authorize The Hartford to report, withhold and deposit the taxes described below.

A. **STANDARD TAX SERVICES**

- The Hartford will withhold and deposit applicable and properly elected additional United States federal income taxes (FIT) and state income tax (SIT) as well as applicable Employee FICA taxes from disability benefits/sick pay. The Hartford will make timely filings with the appropriate United States federal and state agencies.
- The Hartford will deposit the taxes using The Hartford's tax identification number and will timely notify Policyholder/Employer of these payments. This notification is provided to you on the EOB (Explanation of Benefits).
- The Hartford assumes no responsibility for the Policyholder/Employer's share of FICA (unless elected below).
- The Hartford assumes no responsibility for any other payroll or employment related tax, fee, premium or the like including Federal Unemployment Insurance (FUTA) and State Unemployment Insurance (SUTA), State Disability Insurance, State or Local Occupational Taxes, other jurisdictional taxes such as municipal, city or county taxes, or any Workers' Compensation Tax which may be applicable to the disability benefits The Hartford is paying.
- The Hartford will prepare and deliver to Policyholder/Employer the annual summary reports of benefits paid.

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☐ Policyholder/Employer **authorizes** The Hartford to prepare Forms W-2 for payees and file such forms with the appropriate United States federal and state agencies.

- The Hartford will postmark by January 31st of each year, or such other date required by law, Forms W-2 containing sick pay information to payees and make information return filings in accordance with Federal and State requirements regarding income tax, Social Security, and Medicare tax.
- The Hartford will issue Forms W-2 using The Hartford's tax identification number.
- If the Policy is terminated, The Hartford will continue to provide Forms W-2 and make information return filings for disability benefits/sick pay payments on all claims incurred prior to termination of the Policy.

☐ Policyholder/Employer **declines** The Hartford service to prepare Forms W-2 for payees or file Federal and State information returns reporting disability benefits/sick pay. The Hartford will provide Policyholder/Employer by January 15th of each year the information required by Federal law to enable Policyholder/Employer to prepare Forms W-2 for its active and terminated employees.

If Policyholder/Employer declines W-2 services, FICA Match Service may not be selected below.

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C. **FICA MATCH SERVICES (W-2 Services must be selected above if Policyholder/Employer authorizes FICA Match Services.)**

☐ Employer **authorizes** The Hartford to prepare W-2 statements as selected in section B, and to pay Employer's share of FICA taxes (FICA Match Service).

☐ Employer **declines** The Hartford's FICA Match Service and will report and deposit Employer's share of any FICA tax withheld from LTD benefits paid.

D. **HOW TAX SERVICES APPLY TO POLICYHOLDER'S LOCATIONS, DIVISIONS, OR EMPLOYEE CLASSES**

Tax Services selected above apply to all locations, divisions and/or classes of the Policyholder.
☐ Yes ☐ No

If no, the Policyholder must provide The Hartford with a listing of all locations, divisions and/or classes that will have Tax Services that differ from the selection under Section B of this agreement.

E. **GENERAL PROVISIONS**

1. Changing Selected Tax Services

Policyholder/Employer agrees that any service change regarding Forms W-2 must be requested in writing on or before November 15th of the current tax year. Any change in W-2 Services after November 15th may result in Employees receiving Forms W-2 after January 31st or possible duplicate forms issued from both The Hartford and Policyholder/Employer.

Policyholder/Employer agrees that any service change regarding Employer FICA Match service will be effective on January 1st following the date on which a new Tax Service Agreement has been signed and submitted to The Hartford.

2. Accurate and Timely Information

Policyholder/Employer agrees to provide The Hartford with accurate and timely information to provide selected tax services, including information to determine the taxable portion of the benefits. Submission of incorrect taxable portion of benefits by the Policyholder/Employer which later requires The Hartford to retroactively correct claimant net benefits may result in fees payable to The Hartford to cover reasonable processing.

3. Hold Harmless

Policyholder/Employer agrees to indemnify and hold The Hartford harmless from any and all liability, including but not limited to fines or penalties that may result from erroneous, incomplete, or untimely information provided by Policyholder/Employer to The Hartford in connection with the selected tax service and The Hartford's performance of its duties under this Agreement.

Legal Name of Entity

_____ _____
Signature Date

Name and Title of Authorized Signer

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