ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-3404

CASE SET-UP

PLEASE PRINT WITH BLACK INK

SERVICING AGENT INFORMATION

Current Date (MM/DD/YYYY) / /

Agent Name (First / Middle / Last)

Phone No. ( )

Fax No. ( )

Agent No.

Email Address

Regional Sales Manager

BROKER OF RECORD

Agent or Agency Name Mike Turney

Agent or Agency ID No.

GROUP INFORMATION

Group Name

Website Address

Group Address (Street Address / City / State / ZIP+4)

Contact Name

Contact Title

Contact Phone No. ( )

Contact Fax No. ( )

Contact E-mail

1. How many years has the group been in business? _____

2. What are the group's industries? _____

3. How many eligible full-time employees? _____ What number of hours is considered full-time? _____

4. Waiting period: For current employees _____ For new employees _____

5. List any other coverage currently carried by the group and whether it will be replaced with Assurity coverage:

Insurer Name	Type of Coverage	Replacing with Assurity?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

6. Mail policies to: ☐ Insured ☐ Other _____

ENROLLMENT INFORMATION

1. What Assurity products are being considered?

Product			Employer Paid Premium	Employee Paid Premium	Included in Section 125?
☐ Accident Expense+	☐ AE Pro	☐ AE Pro Group	%	%	☐ Yes ☐ No
☐ Critical Illness+	☐ CI Pro	☐ CI Pro Group	%	%	☐ Yes ☐ No
☐ Cancer Expense+	☐ CE Pro	☐ CE Pro Group	%	%	☐ Yes ☐ No
☐ Disability Income+	☐ DI Pro	☐ DI Pro Group	%	%	☐ Yes ☐ No
☐ Hospital Indemnity+	☐ HI Pro	☒ HI Pro Group	%	%	☐ Yes ☐ No
☐ Universal Life	☐ Whole Life Pro	☐ Whole Life Pro Group	%	%	
☐ Term Life+	☐ Term Life Pro	☐ Term Life Pro Group	%	%	

☐ Charitable Benefit Rider Name _____

ENROLLMENT INFORMATION *(continued)*

2. Requested issue date of applications ___/___/___ (MM/DD/YYYY) Date of first deduction ___/___/___ (MM/DD/YYYY)

3. If Disability Income is included in the Section 125, what percentage of the premium is included? ☐ 50% ☐ 100% ☐ Other *(Specify)* _____

4. Open enrollment period _____

5. What is the re-enrollment frequency? ☐ Continuous ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

6. New enrollment start date ___/___/___ (MM/DD/YYYY) New enrollment end date ___/___/___ (MM/DD/YYYY)

BILLING INFORMATION

1. Refund money to? ☐ Employer ☐ Employee

2. What is the billing method? ☐ Payroll deduction ☐ Other *(Specify)* _____

How would you like to be billed? ☐ Ahead ☐ Arrears

What is the payroll deduction frequency mode *(i.e. how should policies appear on the bill)?*

☐ Weekly ☐ Bi-weekly *(26)* ☐ Monthly ☐ 8thly ☐ 9thly ☐ 10thly ☐ 11thly ☐ 13thly

If 9thly or 10thly, list "skip months" *(e.g. June and July, July and August, etc.)* _____

3. Where are the billings sent? ☐ Group ☐ TPA ☐ Other *(Specify)* _____

4. If billing information is different from what is listed in Group Address, please provide. _____

Third party administration *(TPA)* must be approved by and under contract with Assurity. If a TPA is involved, please provide the information below.

Name _____
Street Address *City* *State* *ZIP+4*

Address _____

Additional information or details _____

AGENT SIGNATURE

This Agreement authorizes the contact of employees/members of this Organization concerning insurance to be provided by Assurity Life Insurance Company. Authorization is given to send billings to the location named above. The responsibility in assuring that premiums have been remitted to Assurity on behalf of their employees/members is that of the Organization named above. Either the Organization or Assurity may, upon 30 days' advance notice to the other, terminate this Agreement, in which event the payment of premiums will be a matter of accounting directly between each employee/member and Assurity.

_____ ___/___/___
Signature of Employer Contact *Date (MM/DD/YYYY)*

_____ ___/___/___
Signature of Soliciting Agent *Date (MM/DD/YYYY)*