GROUP/ASSOCIATION **SET-UP FORM**

Please complete this form and fax to: (512) 467-7403 Attn: Group/Association Case Coordinator

- Each Employer/Association must be approved before any business may be written or submitted.
- List Bill Only: Employer must submit applications on at least five lives and must maintain a minimum of five lives to be eligible for list bill.
- Please type or carefully print all of the following information.

EMPLOYER/ASSOCIATION INFORMATION

Employer/Association Name: Tax ID: #

Street Address: Phone Number: ( )

City: State: Zip: Fax Number: ( )

Nature of Business: E-Mail Address:

List Bill Only: Part of Section 125 Plan? ☐ Yes ☐ No If Yes, Identify Plan Administrator:

List Bill Only: Will all employees participate in Section 125? ☐ Yes ☐ No Plan Mode:

PRODUCTS TO BE WRITTEN

☐ American Retirement Life Insurance Company ☐ Loyal American Life Insurance Company *(Referred to as "Company")*

Products to be written: _____

Are any existing products intended to be replaced? ☐ Yes ☐ No If "Yes," which ones:

BILLING CONTACT INFORMATION (List Bill Only)

Should Billing Information be verified with the Agent prior to contacting the employer? ☐ Yes ☐ No

Billing Contact Person and Title: Ext.:

Billing Address *(if different from above):* City: State: Zip:

Is this a third-party administrator? ☐ Yes ☐ No If "Yes", has the TPA been approved by the Home Office? ☐ Yes ☐ No If "No", contact the Company.

Is this a common remitter? ☐ Yes ☐ No If "Yes", we require a letter/agreement showing that the party collecting the premium is an agent acting on behalf of the employer/association.

Is this a multi-location employer? ☐ Yes ☐ No If "Yes", how many and what states:

Will all of the bills be coordinated through one office? ☐ Yes ☐ No

Will this be an electronic enrollment? ☐ Yes ☐ No If "Yes", whose system: **Home Office Approval Code:**_____

BILLING SET-UP INFORMATION

Billing Method *Please select one:* ☐ Monthly Bank Draft ☐ List Bill

Note: To calculate list bill premium, multiply the annual/monthly bank draft premium by the appropriate factor. (See Agent Guide)

Bank Draft Only: *Drafts will occur from:* ☐ Each individual member's account ☐ One employer account

List Bill Only: Premium Billing Order *(Please select one):* ☐ Alpha ☐ Social Security # ☐ Policy #

Billing Frequency *(How often bill is sent):* ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ Other *Refer to the product application for available "other" billing frequencies.*

First payroll deduction date: / / ☐ None: Benefits are employer paid

Requested Issue Date: / / ***(The Issue Date is the day the first payment is due.)***

Note: Policy Issue Dates should be based on at least 5 weekly or 3 bi-weekly deductions having been made. Please refer to the product application for available 'other' billing frequencies.

Billings are mailed 10 days prior to the premium due date. Alternate date requested:

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AGENT INFORMATION

Servicing Agent Name:	Phone Number: ( )
E-mail address:	Fax Number: ( )

If you are requesting Payroll Deduction/List Bill, this section must be completed.

Employer Agrees to PAYROLL DEDUCTION program: ☐ Yes ☐ No

Employer agrees to make payroll deduction of premiums, as authorized by employees, and forward the aggregate sum thereof to the Company, upon the receipt of the list bill. The Employer bears no liability, responsibility, or obligation for the employee's insurance or for the late payment or premium except as provided herein. Employer agrees from the date of payroll deduction, the sums withheld are the property of the Company, and the Employer holds such amounts as an agent of the Company with the sole obligation of remittance.

If Employer mandates a minimum participation level before payroll deduction will be authorized, state participation level here:

_____

The Company agrees to furnish a statement indicating the premium due by each participating employee. Employer agrees to make remittance within 10 days of its receipt of the monthly statement. Employer also agrees to promptly notify the Company of the name, address, and phone number of any participating employee who leaves its employment, or withdraws a salary deduction authorization of from whom payment will not be made. If Employer terminates this agreement by 30 days written notice to the Company, Employer will be fully discharged upon remittance of premiums theretofore deducted. In the event premiums are no longer to be withheld by payroll deduction, the premiums are to be paid directly by the Employee to the Company.

If an Employee's premium is altered from the date of application, the Company will communicate this with the agent at the time of policy issue. It is the agent's responsibility to communicate these changes in premium to the Employer and coordinate the update in premium deduction for the Employee.

AGENT AND EMPLOYER ACKNOWLEDGEMENT:

I understand that only the Company's President, Vice President, or Secretary has the power to modify or amend any policy, coverage, premium, underwriting, or any other procedure or benefit. No agent may accept risks, alter or amend policies or procedures, or waive any provisions of the Payroll Deduction Program or policy. To the best of my knowledge, the information on this form is correct.

Name & Title of Representative: _____

Signature: _____ Date: _____

Servicing Agent Name: _____

Signature: _____ Date: _____

Additional Comments

_____

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