



**This form must be included with all new cases.** Please complete this form in its entirety. An incomplete form may result in delayed processing.

**I. GROUP & CONTACT INFORMATION**

Group Effective Date: \_\_\_\_\_

New Group       Change/File Maintenance – Existing Group

Group/Policy Number: \_\_\_\_\_

Group Name: \_\_\_\_\_  
 (Please print clearly)

SIC Code: \_\_\_\_\_

Group Contact Name: \_\_\_\_\_

Group Contact Email Address: \_\_\_\_\_

Billing Contact Name: (if different than above) \_\_\_\_\_

Billing Contact Email Address: \_\_\_\_\_

**INTERNAL CONTACTS**

RVP: \_\_\_\_\_ FDL Sales Mgr. \_\_\_\_\_ BC Sales Rep.# \_\_\_\_\_ Field Office Code \_\_\_\_\_

Who can we call with questions on this case? \_\_\_\_\_ Phone \_\_\_\_\_

**II. GROUP ADMINISTRATION**

**Benefits Manager** - For ease of administration and/or speed of document delivery, a **Benefits Manager Registration Form** is required and must accompany this transmittal. The form will grant the user access to our Web-based administrative solutions. The form is available at our Web site – [www.fdl-life.com](http://www.fdl-life.com) under the Group Benefits Forms section, under Group Administration.

**A. Document Delivery – All documents will be issued electronically\* unless otherwise indicated below.**

\*A welcome notice and instructions on accessing documents and Administrative Guides, via Benefits Manager are e-mailed to the Group Administrator.

Group does not want documents sent electronically. Please indicate name and address materials should be sent to below.

Name: \_\_\_\_\_

Street Address (No P.O. Box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Additional copy of policy/certificates to be sent to: (If additional space is needed, please provide in Comments section below.)

Name(s): \_\_\_\_\_

Email address: \_\_\_\_\_ OR Mailing address: \_\_\_\_\_

Copy to FDL Sales Office (via mail)

**B. Billing Method (As indicated on Group Application – please select one below)**

**Web Billing** – We provide initial enrollment details through our Web-based application which an employer can use to manage additions, changes, and terminations. We send out a courtesy email reminder for the employer to print their own billing statement.

**Self-Administered** – All enrollment and individual coverage information is kept by the employer and only aggregate coverage information is provided to us monthly along with the premium due.

**List Billing** – Enrollment additions and deletions are managed by us and the bill is presented to the employer with individual enrollment information in paper form.

**Third Party Administration (TPA)** - If TPA, please provide TPA name: \_\_\_\_\_

Is this a new TPA?     Yes     No

If yes, has the TPA been approved by FDL?     Yes     No    If yes, the TPA Agreement must be attached.

**Note:** If any units are to be billed separately: (1) indicate the name and address of each unit in the Comments section below or on an attachment; (2) state the amount of the premium deposit to be applied to each unit; and (3) separate enrollment forms by unit.



**III. COMMISSIONS**

Commissions are payable to (Please check all that apply):

- Broker Agency**     **Producing Agent**     **Managing General Agent/General Agent**

Commission Rate Payable: \_\_\_\_\_%    \_\_\_\_\_%    \_\_\_\_\_%

\*If more than one, list all others in Comments section and indicate split (please indicate Tax ID or SS# for each.)

**The following information must be provided (please print):**

<b>Broker Agency</b> (If applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>AND/OR</b>	<b>Producing Agent</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____		Name: _____
Address: _____		Address: _____
City/State/Zip: _____		City/State/Zip: _____
Tax ID or SS#: _____		Tax ID or SS#: _____
Email: _____		Email: _____
Phone #: _____		Phone #: _____
Percentage of commission payable: _____%		Percentage of commission payable: _____%

**Managing General Agent/General Agent:**     Yes     No

Name: \_\_\_\_\_ Tax ID or SS# \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

Percentage of commission payable: \_\_\_\_\_%

- If commission rate is other than standard, please attach a single case commission agreement.
- If multiple parties are receiving commission, please make sure total percentage of commissions payable is 100%
- Appointed by FDL?     Yes     No    (If No, please include appointment documents)
- If additional commission information needed, please add to the Comments section. Indicate split (please include name, address, Tax ID or SS#, and commission split for each.)

**IV. SUBMISSION CHECKLIST**

- Application or Participation Agreement     Yes
  - Completed Enrollment Forms     Yes (or census)
  - Occupations and Earnings     Yes (required for all groups with LTD coverage)
  - Evidence of Insurability Form (if evidence is required)     Yes
  - Deposit Premium (equal to one billing mode)     Yes
  - Copy of Original Rating and Proposal     Yes
  - Commission Agreement (if applicable)     Yes
  - Producer Appointment Documents (if applicable)     Yes
  - Copy of Prior Carrier's Plan     Yes (required for Vol STD & Vol Dental & all LTD)
  - W-2 Agreement     Yes (Required for all groups with Disability coverage)
  - Benefits Manager Registration Form     Yes (Required for all groups)
  - EAP Account Notice Form (if applicable)     Yes
  - Is there a requirement to provide benefits to match a Bargaining Agreement?     Yes     No
- If Yes, please attach that Bargaining Agreement.



**V. PRODUCTION:** Please complete below.

	<b>Employees</b>		<b>Commissions</b>	<b>Rate</b>	<b>Volume</b>	<b>Monthly Premium</b>
	<b># Elig/# Sold</b>					
Life	_____		_____	_____	_____	_____
AD&D	_____		_____	_____	_____	_____
Dependent Life	_____		_____	_____	_____	_____
STD	_____		_____	_____	_____	_____
LTD	_____		_____	_____	_____	_____
Supplemental Life/AD&D*	_____		_____	_____	_____	_____
Supplemental Life-Spouse*	_____		_____	_____	_____	_____
Supplemental Life-Children*	_____		_____	_____	_____	_____
Voluntary Life - EE	_____		_____	Age	_____	_____
Voluntary Life - SP	_____		_____	Age	_____	_____
Voluntary Life - CH	_____		_____	_____	_____	_____
Voluntary AD&D - IND	_____		_____	_____	_____	_____
Voluntary AD&D - FAM	_____		_____	_____	_____	_____
Voluntary STD	_____		_____	Age	_____	_____
Voluntary LTD	_____		_____	Age	_____	_____
Vol Dental - EE	_____		_____	_____	_____	_____
Vol Dental - EE + Spouse	_____		_____	_____	_____	_____
Vol Dental - EE + Child(ren)	_____		_____	_____	_____	_____
Vol Dental - Family	_____		_____	_____	_____	_____
Other	_____		_____	_____	_____	_____

- Do any of the following apply:
- |                                    |                          |                          |           |        |     |     |
|------------------------------------|--------------------------|--------------------------|-----------|--------|-----|-----|
|                                    | Yes                      | No                       | LIFE/AD&D | DL     | STD | LTD |
| • Multi-Coverage Discount Strategy | <input type="checkbox"/> | <input type="checkbox"/> | _____%    |        |     |     |
| • Inforce Discount Strategy*       | <input type="checkbox"/> | <input type="checkbox"/> | _____%    | _____% |     |     |

\*If Yes, include a copy of prior carrier's bill, renewal letter, and current certificate.

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_