



AFA NEW BUSINESS SUBMISSION FORM
(TO BE COMPLETED BY THE AGENT)

TO AVOID ANY PROCESSING DELAYS, PLEASE COMPLETE THE ENTIRE FORM

- 1. Date _____
- 2. Requested Effective Date _____
- 3. Who completed this form? _____
- 4. Phone # _____

SECTION 1: AGENT INFORMATION

- 5. Agent of Record (Name and #) _____
- 6. Phone # _____
- 7. Fax# _____
- 8. Email Address _____
- 9. If AFA Account Representative is involved: Name and # _____
- 10. Who is signing the applications? Name and # _____ (If more than 2, attach list w/agents name & #)
- 11. Are commissions being split/adjusted? Yes No **If Yes, attach Alternate Commission Agreement**

SECTION 2: EMPLOYER INFORMATION: 12. NEW GROUP Yes No--- If no, indicate MCP# _____

- 13. Firm Name _____
- 14. Phone# _____
- 15. Fax # _____
- 16. Federal ID# _____
- 17. Nature of Business _____
- 18. Firm's Physical Address _____
- 19. Firm's Contact Person/Title _____
- 20. Does the firm have employees w/residents outside the firm's resident state? Yes No If yes, list states _____
- 21. Are all employees covered by Worker's Compensation? Yes No
If no, please explain _____
- 22. If employer has section 125 & selling Disability Shelf Plans 60% or 70% of salary?

SECTION 3: BILLING INFORMATION

- 23. Firm's Mailing/Billing address (If different than # 18) _____
- 24. Are multiple billings required? Yes No
If yes, attach a list of each location and their physical address. (NOTE: Agent must be licensed and appointed in each state)
- 25. Reason for multiple billings _____
- 26. How is Payroll deduction made? Current (EX: Deducted in May for June)
 Arrears (EX: Deducted in June for June)
- 27. Mail premium notice to: EMPLOYER COPY AGENT **Third Party Payor # _____ **

** Third Party Payor must be **Pre-Approved by Home Office**. A letter from the firm must be must submitted with the business requesting that their billings be sent to the Third Party Payor. The Third Party payor must also sign a Privacy Non-Disclosure Agreement.

- 28. Third Party Payor's name/ mailing address: _____
- 29. Third Party Payor's Contact Person/Title: _____