

SISLink™ NEW BUSINESS SUBMISSION FORM

PLEASE FULLY COMPLETE THE ENTIRE FORM, FRONT AND BACK, TO AVOID ANY PROCES SING DELAYS.

Date: _____

Requested Effective Date: _____

EMPLOYER INFORMATION:

Firm Name: _____

Address: _____

Phone #: _____ Fax #: _____ Federal ID #: _____

Nature of Business: _____

Contact Person/Title: _____

Does the firm have employees residing outside the firm's state of domicile? Yes No If yes, list states: _____

GROUP MAJOR MEDICAL INFORMATION:

Group Major Medical Insurance Carrier: _____

When did current coverage go into effect? _____ What is current waiting period? _____

When does an individual's coverage under the plan become effective? 1st day of month immediately following the end of the waiting period
 1st day immediately following the end of the waiting period

Name of employees that have been denied coverage: _____

If an employee rejected coverage, does the employer keep a signed form on record indicating such rejection? Yes No

Does employer allow employees who previously declined coverage to enroll: at any time
 only during designated periods of open enrollment

If enrollment allowed only during periods of open enrollment, when is open enrollment allowed? _____

Please note, a copy of your current major medical benefit schedule, reflecting the individual in-network deductible and individual in-network out-of-pocket maximum, must be attached to this form.

BILLING INFORMATION:

Mailing/Billing Address: _____

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.)

How are payroll deductions made? Current (example: June premiums deducted in May)
 Arrears (example: June premiums deducted in June)

AGENT INFORMATION:

Agent of Record: _____

Mailing Address: _____

Phone #: _____ Fax #: _____

E-mail: _____

A completed and signed Single Case Agreement must be submitted with this form.