Reset

FIRST RSL SMARTCHOICE ™
BENEFIT SOLUTIONS FOR SMALL BUSINESS

FIRST RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Underwritten by First Reliance Standard Life Insurance Company (FRSL)

Request for participation and enrollment form

2-19 Lives for Life, LTD, STD & Dental*

Submission requirements …

- ☐ Completed SmartChoice Request for Participation & Enrollment form
- ☐ Initial deposit check equal to monthly premium amount
- ☐ Copy of sold proposal premium summary page(s) as presented to the employer

If applicable …

- ☐ Prior carrier information required for Dental, STD and LTD coverage takeover
- ☐ Notification of Waiver Form(s)
- ☐ Evidence of Insurability Applications for Life benefits exceeding Non-Medical Issue Limits
- ☐ Quarterly State Wage Reports may be requested at the discretion of the Home Office.

(If any of the above items are missing or incomplete, processing of case may be delayed.)

Effective dates of coverage are always the first of the month. All new business submission material must be received by FRSL prior to the requested effective date. If later, the case effective date will be the first of the month following receipt.

* To write a (2) employee dental group, two additional lines of coverage must also be sold.

First Reliance Standard Life Insurance Company

Employer Information

Please fill in where appropriate. Incomplete applications will delay processing.

Employer's Legal Name _____ Employer's Tax ID# _____

Employer's Business Address _____

City _____ State _____ ZIP Code _____

Firm Contact _____ Title _____ Telephone (_____) _____

Fax (_____)_____ E-mail address_____ Effective Date Requested___ /___ /___

Years in Business _____ SIC Code & Nature of Business _____

Preferred method of billing: ☐ **Electronic*** ☐ **Paper** *** For firms applying for Dental/Vision, Electronic billing not available.**

Type of Business Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other _____

Should K1 Earnings be included in Definition of Earnings shown below? ☐ Yes ☐ No

Are any subsidiary or affiliated companies to be insured? ☐ Yes ☐ No

(If yes, please provide name(s), address(es), and nature of business with this application)

Is there any other Group or employer sponsored Individual Life/AD&D, Dental, Eye Care, STD, or LTD coverage in force or currently being applied for on some or all employees? ☐ Yes ☐ No

If yes, please specify type(s) and effective date(s) of coverage:

_____

_____

Definition of Earnings (for Life/AD&D, Short and /or Long Term Disability): Basic salary exclusive of overtime, bonuses and other special forms of compensation. Commission earnings will be based on the average earnings of the previous 24 months. (K1 Earnings included if applicable)

Definition of Employee Eligibility: Eligible employees are those actively working full time for a minimum of 30 hours per week year round (non-seasonal) who have satisfied the employer's minimum service requirement. Eligibility may be modified to include part-time employees working a minimum of 20 hours per week, provided less than 25% of the eligible employees are working less than 30 hours per week.

Employer's Minimum Service Requirements

A. All employees actively at work on or before the coverage effective date are eligible following the completion of:
☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days of active service

B. All new employees (actively at work after the coverage effective date) shall become eligible on the first day of the month following the completion of:
☐ 30 days ☐ 60 days ☐ 90 days of active service

Definition of Dependent Eligibility (For Dental): Eligible dependents include the insured employee's spouse and unmarried children prior to their 19th birthday who do not work for the firm. In addition, unmarried children from their 19th birthday to the day before their 24th birthday are eligible if they are full time students attending an accredited educational institution and primarily dependent upon the employee for support and maintenance. NOTE: Dependent ages may vary by state.

Participation Requirements:
For groups of 2 eligible employees – both eligible employees must be insured
For groups of 3 to 5 eligible employees – all eligible employees but one must be insured
For groups of 6 to 9 eligible employees – all eligible employees but two must be insured
For groups of 10 to 19 eligible employees – 75% of all eligible employees must be insured
(If employees do not contribute toward cost of insurance, there must be 100% eligible employee participation)

- If classes of employees are insured, these participation minimums must be maintained within each class.
- For Dental coverage, these participation requirements apply to eligible dependents as well.
- For Dental coverage, employees and dependents that are covered for group dental elsewhere may be counted toward satisfying participation requirements with submission of signed waiver forms.

First Reliance Standard Life Insurance Company

Life/Accidental Death & Dismemberment (AD&D) (2 to 19 Lives)

Benefit Schedules: Option I Coverage based on ☐ 1x annual earnings ☐ 2x annual earnings Maximum Benefit _____

Option II Flat Amount Coverage of _____ for each employee ($10,000 minimum)

Number of Employees	Non-Medical Maximum Limit*	Maximum with Evidence
Insure 2-5	$ 50,000	$200,000
Insure 6-9	$ 75,000	$200,000
Insure 10-19	$100,000	$200,000

***Amounts elected in excess of the non-medical maximum limits will require medical underwriting**

Employer will pay _____ % of employee premium Employer will insure ☐ all employees
(employees may contribute up to 100% of premium ☐ one or more classes of employees (describe below)
where permitted, provided all participation requirements are met)

_____

_____

Participation: Total number of eligible employees _____
Total number of employees applying _____

Dental (2 to 19 Lives) Choose Plan

Plan Selected (Annual Plan Maximum)	☐ Plan A ($1,000)	☐ Plan B ($1,500)	☐ Plan C ($1,000)
- Add the MAC Option:	☐	☐	☐
- Add the Eye Care Option:	☐	☐	☐
- Increase to a 24 Month Initial Rate Guarantee	☐	☐	☐
- Increase to a $2000 Annual Plan Max	**N/A**	☐	**N/A**
- Move Endodontic Coverage to Basic Services	☐	☐	**N/A**
- Move Periodontic Coverage to Basic Services	☐	☐	**N/A**
- Add Reduced Participation Option	**N/A**	**N/A**	☐
- Non-Mac Plans – Increase Out Of Network Allowance to 90TH Percentile	☐	☐	**N/A**

Takeover – Is this plan replacing another Group Plan? ☐ Yes ☐ No If, yes, provide the following:

A. Name of carrier/policy number _____

B. Effective date of prior plan _____ C. Termination date _____

D. Attach a copy of the prior carrier's last bill

Elimination Period:

1. For Plans A , B, & C, there is a 12 month Major services elimination period for all current insureds which can be waived, along with "credit" given for calendar year deductibles accumulated under the prior plan, when First Reliance Standard replaces a comparable dental plan that has been in effect continuously for at least 12 months prior to the effective date of Plan A, B or C.
2. For Plan B, there is a 24 month elimination period for Orthodontic coverage for groups of 2 – 9, which cannot be waived. For groups of 10+, there is a 12 month elimination period for Orthodontic coverage for all current insureds which can be waived on Takeover.
3. Current insureds are all employees and dependents insured on the First Reliance Standard effective date. New hires to the group after the effective date must fulfill the usual elimination periods and deductibles.

Employer will pay _____ % of employee premium Employer will insure ☐ all employees
_____ % of dependent premium ☐ one or more classes of employees (describe below)
(employees may contribute up to 100% of premium _____
provided all participation requirements are met) _____

Participation: Total number of eligible employees _____ Total number of employees enrolling _____
Total number of employees waiving (due to coverage elsewhere) _____

First Reliance Standard Life Insurance Company

Short Term Disability (2 to 19 Lives)

Benefit Schedules:

Option I Percentage of Earnings Plan ☐ 50% ☐ 60% ☐ 66.7% ☐ 70% (up to maximum benefit)

Option II Flat Benefit Per Week of _____ (not to exceed 70% of weekly earnings up to maximum benefit)

(Benefits for employees working in New York are subject to a maximum weekly benefit amount of 20% of weekly earnings up to the maximum benefit)

Maximum Benefit: $1,500 per week

Plan Duration: ☐ 13 weeks ☐ 26 weeks

Is this plan replacing another Group Plan?

☐ Yes (if yes, attach a copy of prior carrier's last bill and copy of contract or certificate of insurance)
☐ No

Employer will pay _____ % of employee premium (employee may contribute up to 100% of premium provided all participation requirements are met)

Employer will insure ☐ all employees
☐ one or more classes of employees (describe below)

_____

_____

Participation: Total number of eligible employees _____
Total number of employees applying _____

Long Term Disability (2 to 19 Lives)

Benefit: 60% of Earnings up to a maximum of $7,500 per month

Benefit Duration: Up to Normal Retirement Age* for accident / illness

*Normal Retirement Age, as defined by the 1983 Amendments to the United States Social Security Acts as determined by year of birth.

Elimination Period: ☐ 60 days ☐ 90 days ☐ 180 days

Is this plan replacing another Group Plan?

☐ Yes (if yes, attach a copy of prior carrier's last bill and copy of contract or certificate of insurance)
☐ No

Employer will pay _____ % of employee premium (employee may contribute up to 100% of premium provided all participation requirements are met)

Employer will insure ☐ all employees
☐ one or more classes of employees (describe below)

_____

_____

Participation: Total number of eligible employees _____
Total number of employees applying _____

First Reliance Standard Life Insurance Company

Application Signatures

I (We) verify that all employees applying for coverage are actively at work and meet the eligibility requirements specified in the plan descriptions; that all employees applying for coverage do not work where they reside; and that all employees, including myself, who are applying for disability coverage do not have other disability insurance currently in force or applied for, that when added to this insurance would exceed 100% of his/her individual current monthly earnings.

I (We) verify that FRSL benefit plan(s) have been offered to all eligible employees. Completed waivers are attached for those employees and their dependents electing not to participate in the plan(s).

The undersigned employer requests that insurance be provided in accordance with employer's specifications for Group Insurance to which this request is attached and shall be subject to the terms of the Group Insurance Policies issued to the group by FRSL. The undersigned employer agrees that it will remit to the insurer regularly in advance, the required premiums as they become due.
We have read this form and understand that:

1. This request for coverage is not effective until approved by FRSL in writing. FRSL reserves the right to decline any case so coverage may be declined or the effective date may be deferred for incomplete submission of information as outlined in FRSL underwriting rules/standards. **Existing coverage should not be terminated until written approval has been received.**

2. All information given in connection with this request for participation is true and complete.

3. FRSL reserves the right to re-rate any coverage retroactively to the effective date or take other appropriate actions if any information provided to us is not true or is incomplete. Please note that changes to the census data, from what was originally submitted, may affect rates. Final premium rates are subject to final enrollment.

4. No provider can make or modify a contract for FRSL and all coverage will be as stated in FRSL policies.

5. Attached is an initial deposit check payable to FRSL equal to the estimated first month's premium. The amount will be returned if insurance does not become effective. Cashing of the check by FRSL does not constitute an approval of request.

FRAUD WARNING (NOT APPLICABLE TO LIFE INSURANCE): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____
Employer's Signature (Owner, Partner, CFO) Date

Premium Summary

Billing Mode (select one)	☐ Monthly Billing	☐ Quarterly Billing (3X monthly premium)
Dental	$ _____	$ _____
with Vision	$ _____	$ _____
Short Term Disability	$ _____	$ _____
Life/AD&D	$ _____	$ _____
Long Term Disability	$ _____	$ _____
Administration Fee*	$ _____	$ _____
* $5.00 Electronic / $12.00 Paper Billing		
Total SmartChoice Bill Amount	$ _____ Monthly	$ _____ Quarterly

I have complied with the underwriting rules and have explained the coverage in detail to the employer.
I represent that all information on this application is correct to the best of my knowledge.

X _____ _____
Producer's Signature Date

First Reliance Standard Life Insurance Company
Census Information

	Employee's Social Security Number	Name (Last Name First)	Date of Birth M / D / Y	Sex M / F	Date of Hire M / D / Y	Occupation	Current Monthly Salary	Hours Worked Per Week	Coverage Selected			
									LTD	STD	Dental Status*	Life/ AD&D
1.												
2.												
3.												
4.												
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18.												
19.												

***For Coverage Selected Dental** — Use status indicators of “S” for single, “+1” for employee plus one dependent or “F” for family coverage.

First Reliance Standard Life Insurance Company

Notification of Waiver Form (This form may be photocopied)

Please read, complete and sign this form if you are contributing toward the cost of coverage and are waiving coverage for any of the following insurance products: Life, Dental, STD and/or LTD.

Note: Under contributory plans (where employees contribute towards the cost of coverage), eligible employees may elect to waive coverage. However, election to waive may not exclude that employee from the employer's participation requirements. Under non-contributory plans, all eligible employees must enroll. Eligible employees are defined on Page 1 of the Request for Participation and Enrollment form.

Employee's Name: _____

Name of Employer: _____ Policy Number(s): _____

Employee Date of Birth: _____ Social Security Number: _____

Please check the box for type(s) of insurance coverage you are waiving:

☐ Life ☐ Dental ☐ STD ☐ LTD

If you are waiving dental coverage for yourself or your dependents, check all boxes that apply and provide information as applicable:

☐ I have similar dental coverage under my spouse's plan

☐ My dependents have similar dental coverage under my spouse's plan

If either or both above boxes are checked, please provide the following information:

Name of spouse's insurance company: _____

Spouse's plan effective date: _____

☐ I do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage
☐ My dependents do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage

Please read and sign:

I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from First Reliance Standard Life Insurance Company being offered by my employer. With my signature, I certify that I have decided to waive coverage as indicated above.

I understand that in the event I request to purchase such insurance at a later date: 1) I will be required to furnish evidence of insurability for myself (and any dependents, if such coverage is available) at my own expense; and 2) First Reliance Standard Life Insurance Company will have the right to refuse my request. For dental coverage, I may be subject to reduced benefits.

Signature _____ Date _____

First Reliance Standard Life Insurance Company

Producer's Statement

Name of Employer to be Insured _____

Attention Producer: This enrollment form must be completed in full. Missing information will delay the new business process. Make sure that all applicable submission requirements outlined on the cover page of the request for participation and enrollment form are completed.

Producer Instruction: If you are currently appointed with First Reliance Standard Life, you need only to complete the license number, First Reliance Standard Life producer number, and signature.

Producer Information (please type or print legibly):

Name _____ License number _____ State _____
Last Name First Name MI

Agency Name (if applicable) _____

Are you appointed with FRSL? ☐ Yes ☐ No (if yes, FRSL producer number _____)

Address _____

City _____ State _____ ZIP Code _____

Social Security Number or Tax ID Number _____

Telephone (_____)_____ E-mail _____ Fax (_____) _____

Pay Commissions to _____

Producer's Signature _____ Date _____

RSO: _____ Sales Representative/Manager: _____