TheStandard™
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New Business Submission Checklist

To ensure that your application for group insurance is processed correctly and in a timely manner we will need the following:

- ❒ **Application for Group Insurance** – Please review application and verify that it has been completed in its entirety.
- ❒ **Check for first month's premium (based upon information from the sold proposal),** payable to Standard Insurance Company (for New York situsedcases -- Standard Life Insurance Company of New York)
- ❒ **Copy of "Sold" Proposal and any supporting documentation**
- ❒ **Complete Census** – including employees' First and Last name, Date of Birth, Date of Hire, Occupation, Social Security # (if list billing), Insured Earnings, and Gender. Voluntary or contributory coverages will require enrolled benefit information and/or enrollment forms. Please email to your sales representative in an Excel compatible format.
- ❒ **Prior Carrier policy and a copy of their most recent billing statement** – for takeover groups only

Other completed forms, if applicable:

☐ **Reports Online Agreement** ☐ **Medical History Statements**
☐ **STD FICA Service Agreement** ☐ **Cobra Agreement**

Group Information:
Legal Name of Policyholder:_____
(Legal Name of Policyholder must match name on the group Application)

Executive Correspondence Contact:_____
Administrative/Claims Contact:_____
E-Services Administrative Email address: _____
Administrative/Claims Contact phone number and address if different from Policyholder's:
_____

Is the Billing contact and Billing address the same as the Administrative contact? ☐ **Yes** ☐ **No**
If No, please provide Billing contact's name, address, phone number and email address:
_____
_____

ERISA Plan # (s): Life _____ LTD _____ STD _____ Dental _____
(Needed for groups over 100 lives)

Employer Tax ID #_____

Affiliates - ☐ **Yes or** ☐ **No** If yes, please provide the following information for all affiliates to be included:
Full Legal Name:_____
Address, City, State, Zip: _____
Tax ID #: _____**Nature of Business:** _____

Definition of a Member - Describe the person to be insured. Include separate descriptions if they vary by coverage.
□ All active employees and partners (if partnership) regularly working 30* (or____) more hours per week.
□ All active employees and partners (if partnership) regularly working 30* (or____) more hours per week that participate in the employer sponsored medical plan.
□ Other (include "hours per week" requirement) _____
(*NOTE: Rates may vary if member definition covers employees who work less than 30 hours per week)
Employer Contributions – Does Employer pay 100% of premium for each coverage being requested? □ **YES** □ **NO**
If NO, what percentage of premium does the Employer pay? Please provide details for each coverage requested_____

Form of Organization – select one

❑ C-Corporation	❑ Partnership
❑ S-Corporation	❑ School District
❑ Government Unit / Public Unit	❑ Sole Proprietorship
❑ Limited Liability Company	❑ Trust
❑ Association	❑ Other (please describe)

Eligibility Waiting Period for current employees:
❒ All are eligible regardless of length of service
❒ Only those who have satisfied the waiting period as selected below are eligible.

Eligibility Waiting Period for New Employees: (hired after effective date)
❒ First of the Month coinciding with or next following ___ days as a member.
❒ First day after ___ days as a member.
❒ First day of the month coinciding with or next following becoming a member.
❒ No waiting period.
❒ Tied to Medical plan. Medical plan waiting period ___ days.
❒ Other – (if different EWP for each coverage or Class requested please describe in detail):

Credit Time Served (Part-Time employees to Full-Time employees) Details:
_____

Definition of Earnings – Earnings definition will automatically include base salary, commissions averaged over 12 months, shift differential pay, Internal Revenue Code 401(k), 403 (b), or 456 deferred compensation, executive nonqualified deferred compensation and contributions to fringe benefits under an Internal Revenue Code Section 125 plan.
❒ Normal wording as stated above.
❒ All of the above except commissions.
❒ Base salary only (does not include commissions or shift differential)
❒ S-Corporation/Limited Liability Wording
❒ If any other compensation is to be included or excluded, please describe.
❒ Include Bonuses averaged over 36 months. Bonuses included in the census? ☐ YES ☐ NO
If no, please provide a census including bonus information.

❒ **Does Definition of Earnings vary by coverage? If so, please describe below:**

Plan Year Ends on: Month:_____Day:_____

Billing Type – Check One: □ **List Billing** □ **Self-Admin Billing** (groups with 100 or more lives will be Self-Admin)
Should the billing be separated by departments and/or divisions? ☐ YES ☐ NO
If yes, please provide details and indicate on census for each employee.

Certificates: ** **Hidden Schedules or Separated by Class? If so, please provide details**:

- ❒ **Yes**, I would like a printed supply of certificates. Please ship to: (**No P.O.Box**)
  Attn:_____ Address:_____
- ❒ **No**, I do not need a supply of printed certificates. I will get the electronic version online once it is available through AdminEase.

Broker Information: Necessary information for all individuals/firms receiving commissions.

Broker: _____
Firm: _____
Address: _____
Phone: _____
Fax: _____
Commissions paid to: □ Individual □ Firm
Appointed with Standard? □Yes □No

SPLIT: _____%

Broker: _____
Firm: _____
Address: _____
Phone: _____
Fax: _____
Commissions paid to: □ Individual □ Firm

Additional Comments: