Administration and Benefit Supplement Sheet

Legal Name of Group: ___________________________________

1. Group Contact Information

Who is the Main Contact at your group? (This is the contact for Policy and Compliance Administration.)

Name: ______________________ Phone #: ____________ Email: ______________________

Who should we set up as the Primary Benefit Administrator for our website?
Note: this person will be in charge of the web account and can delegate access to other users.

Name: ______________________ Phone #: ____________ Email: ______________________

2. Subsidiaries/Divisions

Does your company have any divisions or subsidiaries?

☐ Yes ☐ No

If yes, please provide location information (use page 3 if there is more than one).
Name: ______________________ Tax ID: ______________________
Address: ______________________ City/State/Zip: ______________________

3. Aggregator or Third Party Vendor Administration

Does your company use an outside vendor to help administer member eligibility?

☐ Yes ☐ No

If yes, please provide contact information below:
Vendor Name: ______________________ Contact person: ______________________
Phone: ______________________ Email: ______________________
Address: ______________________ City/State/Zip: ______________________

4. Billing Administration

Who is the billing/administrative contact at your group?

☐ Same as main contact.
☐ Different than main contact (this would be the billing administrator, TPA, vendor, or Aggregator.)
Name: ______________________ Phone #: ____________ Email: ______________________

Please select your billing option (there are two choices, please select one):

☐ Self-Billing: Your company will handle employee administration and send LFG the total # of lives, volume and premium by line of coverage on a monthly basis. *(NOTE: Periodically LFG will request a back-up census.)*
☐ List-billing: LFG will provide a monthly invoice showing all members and applicable premiums by line of coverage.

Where should we mail the invoices? (Please select one.)

☐ Use address on the application.
☐ Different address: ______________________ City/State/Zip: ______________________

Payroll Deduction Cycle (for Employee paid benefits):

☐ Monthly (12) ☐ Semi-monthly (24) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Other: ____________

Structure of List-Bill Invoices (there are three choices, please select one):

☐ One bill, with members listed alphabetically from A-Z
☐ Please provide separate invoices by location/line of coverage (add details to the "Special Instructions" section on page 3).
☐ Please sort my bill by sub-groups (add details to the "Special Instructions" section on page 3).

Accident & Critical Illness Billing (if applicable):

☐ Self-Billed: You will remit the premium amount deducted during the remittance period and provide a member level deduction listing along with the payment. You pay as **deducted**.
☐ List-Billed: LFG will provide you an invoice on a monthly basis or every four weeks (depending on how you deduct). The invoice will show each Employee's premium broken out by coverage. You pay as **billed.**

Deduction mode: ☐ Monthly (12) ☐ Semi-monthly (24) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Other: ____________

5. ERISA

Does your company have an ERISA Plan Number?

☐ Yes –Please provide:
☐ Plan Year End Date: ____________ Plan #'s: ☐ Life________ ☐ STD________ ☐ LTD________ ☐ Dental________
☐ Vol Life ________ ☐ Vol STD________ ☐ Vol LTD________ ☐ Accident________ ☐ Critical Illness ________
☐ No – we are not subject to ERISA and/or we have not filed for an ERISA number with our tax advisor.

***If the ERISA plan administrator is different than main contact, please provide details below.*

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6. Replacing coverage *(This applies to STD, LTD and Dental)*

If yes, please provide a copy of the prior carrier booklets (this is needed for Claims purposes):

☐ Attached
☐ Will be provided in a future email

7. Additional Benefits

Are the following benefits included?

Dependent Life (on Basic Life policy): ☐ Yes ☐ No If Yes, Employer Contribution is __________%
Stand Alone AD&D: ☐ Yes ☐ No *(This is a separate Voluntary AD&D policy from the Life or Voluntary Life.)*

8. Minimum Hours *(State restrictions may apply.)*

How many hours per week do employees need to work to be eligible for coverage?

☐ _______(Standard for Full-Time is 30 hours per week)
☐ Varies by class (please add details to comment section on page 3)
☐ Are Part-Time Employees included? ☐ Yes ☐ No ☐ Hours worked per week: ____________________

9. Waiting Period *(State restrictions may apply.)*

When will New Hires be eligible for coverage?

☐ Date of Hire
☐ ________Days ☐ ________Months ☐ ________Years ☐ Other: ______________________________

Do you have any current employees who are still in the above waiting period?

☐ Yes ☐ No

If yes, when are these employees eligible for coverage?
☐ Policy Effective Date ☐ After completion of the new hire waiting period
(NOTE: Employees who have already satisfied the waiting period will go on the plan(s) immediately.)

When Part-Time Employees move to Full-Time status:

☐ The waiting period will begin the day the Employee moves from Part-Time to Full-Time status. *(This is standard.)*
☐ Any time incurred as a Part-Time Employee will count toward the new hire waiting period.

10. Employee Effective Date *(State restrictions may apply.)*

After the waiting period is satisfied, when will the employee be effective?

☐ Not applicable – employee is effective on date of hire.
☐ The day following completion of the waiting period.
☐ First of the month following completion of the waiting period. *(NOTE: If the end of the waiting period lands on the first day of the month, Employee will be effective the first day of the next month.)*
☐ First of the month following/coinciding completion of the waiting period. *(NOTE: If the end of the waiting period lands on the first day of the month, Employee will be effective that same day.)*
☐ Other: ______________________________

11. Rehire Provision

If an Employee leaves your company due to layoff or termination and is rehired, his/her benefits will be effective:

☐ Date of return if rehired within the first 12 months.
☐ After completing new hire waiting period, as indicated in Section 9 above.
☐ Other – will discuss during the administration call. *(Some state restrictions may apply.)*
(NOTE: Benefits for employees returning to work within 6 months for Leave of Absence will be effective on the date of return.)

12. Definition of Earnings

Please check all that apply. If selecting Prior Year W2's, then choose tax year or calendar year (earnings are determined on last day worked).

☐ Base pay ☐ Commissions ☐ Overtime ☐ Bonus (averaged over _____months)
☐ Prior tax year W2's ☐ Prior calendar year W2's ☐ Other: ______________________________

Do you have any K-1 Earners?

☐ Yes ☐ No If yes, we will use: ☐ Prior tax year K-1 earnings ☐ Prior calendar year K-1 earnings

13. Funding

Does your group have a Section 125/Cafeteria Plan?

☐ Yes ☐ No

If Yes, does **Employee** premium come from the section 125/Cafeteria Plan? ☐ Yes ☐ No
Check applicable coverages: ☐ Dental ☐ Vision ☐ Short Term Disability ☐ Long Term Disability ☐ Accident ☐ Critical Illness

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14. Location of Employees

Do you have any employees working in CA, HI, NJ, NY or RI? If so, how many, in what states, and how many are covered by the state disability plans?

☐ Yes ☐ No | If yes, how many, in what state, and how many are covered by the state disability plan? ______________________

Do you have any employees working or living outside the United States?

☐ Yes ☐ No | If yes, how many, where, expected return date? ______________________

15. Enrollments

☐# of eligible Employees____________ | How are we enrolling? ☐ Census ☐ Enrollment Forms ☐ Both

16. Certificates

For your convenience, we will email an electronic copy of the contracts, certificates and initial billing to you at the end of onboarding, unless you indicate otherwise in the note section below. Certificates will be available for you to download and distribute to covered employees. If a paper supply of certificates is needed, please indicate by checking the box below.

☐ Paper If box is checked, please indicate how many are needed: ________________

17. Taxability for Disability Benefits

For Short Term Disability, do you want LFG to pay the Employer's portion of FICA taxes?

☐ Yes: LFG will pay the Employer's portion of FICA taxes. In addition, LFG will automatically print and mail the W2's to the Employee. *(Additional rates may apply for FICA match service.)*

☐ No: LFG will provide monthly FICA reports. Your company will pay the Employer's portion of FICA taxes.

If "No", please select ONE of these options:

☐ W2's are not needed, as Employer plans to add STD payments to the Employee's regular wage W2.

☐ LFG will print and mail the W2 paperwork to the Employer in January of each year (this will have the Employer's company name and EIN). Employer is responsible for reviewing the paperwork for accuracy, distributing W2's to Employees, and reporting W2's to the government.

NOTE: FICA match and W2 Reporting are automatically included for Long Term Disability at no additional charge.

For contributory Short Term and Long Term Disability benefits, the Employee's premium is funded from:

☐ Pre-Tax Payroll Deductions: Employees will receive the benefit after taxes (LFG will withhold taxes).

☐ Post-Tax Payroll Deductions: Employees will receive the benefit with no taxes taken out.

Completed By:

______________________________ ______________________

Broker or Client Name (Type or write in.) Date

Special Instructions (please use additional space, if needed):

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