

☐ **Preliminary Application for Group Insurance** -Original, signed & dated by effective date by Employer and Broker  
(State specific for: AR, CO, DC, FL, KY, LA, ME, MN, NJ, NM, NY, OH, PA, VA)

☐ **Deposit check** equal to approximately 1<sup>st</sup> month's premium

☐ Copy of **Sold Proposal**

☐ For takeover groups, prior carrier's **Booklet** and **Bill**

☐ **Updated Census List** in lieu of cards with applicable info (for contributory cases, employer holds enrollment cards with waiver info.)  
- Name, DOB, Gender, Hire Date, Job Title, Salary & Mode, State & Zip, Class, Coverage elected & SS # (Voluntary & list billing)

*If Applicable:*

☐ **Questionnaire(s):** ☐ **LTD** ☐ **Bonus Formula** (if bonuses are included in Earnings Definition)  
Special Risk: ☐ **Travel Accident (SR)** ☐ **Aircraft &/or Crew Member** (Aircraft SR/VAR)

☐ For state mandated disability plans, **NY DBL** application: DBL-APP-0103 or **NJ TDB** application TDB-APP-0801 & state form DP-1

☐ **Telephonic Claim Intake Client Notification Form** (option for STD/TDB/DBL 250+ lives)

☐ **Evidence of Insurability Forms** for ee's/dependents applying for amounts greater than non-medical maximum or late enrollees  
(ee's not on prior contributory plan who did not enroll within 31 days of eligibility) (State specific forms based upon group situes  
in: AR, CA, CO, DC, FL, GA, IL, KY, ME, MD, MI, MN, MO, NJ, NY, NC, ND, OH, OK, PA, RI, TN, VT, VA or WI)

☐ **Unions.** If union employees are to be covered, please provide all applicable pages of the Collective Bargaining Agreement(s).

<b>Employer Information (to supplement Preliminary Application)</b>	Full Legal Name of Group:  (exactly as to be shown in contract with exact abbreviations, punctuation, or capitalization)		Website Address:	
	Executive Contact Name:		Routine Contact Name:	
	Phone #:	Fax #:	Phone # :	Fax #:
	E-mail address: _____		E-mail address: _____	
	Location: <input type="checkbox"/> Main <input type="checkbox"/> Other:		Location: <input type="checkbox"/> Main <input type="checkbox"/> Other:	
When did <b>Company Operations</b> begin? Month _____/Year _____				
<b>100+ lives:</b> Should we use Policy Anniversary as reporting date for <b>5500</b> ? <input type="checkbox"/> Yes ( <i>standard</i> ) <input type="checkbox"/> No, use _____				

Sold Coverages:	Basic		Dependent	Supplemental		Voluntary		Disability				Travel Accident (SR)
	Life <input type="checkbox"/>	AD&D <input type="checkbox"/>		Life <input type="checkbox"/>	AD&D <input type="checkbox"/>	Life <input type="checkbox"/>	AD&D <input type="checkbox"/>	STD <input type="checkbox"/>	ASO <input type="checkbox"/>	DBL <input type="checkbox"/> TDB <input type="checkbox"/>	LTD <input type="checkbox"/> Vol. <input type="checkbox"/>	
<b>Employer Contributions:</b>												100%
<b>Sold Rates/ Premium:</b>	/\$1,000	/\$1,000	/unit	<input type="checkbox"/> Step rates attached		<input type="checkbox"/> Step rates attached		/\$10	/ee		/\$100	/year

For all **contributory** coverages, please provide: Total # of eligible employees: \_\_\_\_\_ Total # participating: \_\_\_\_\_

Is any coverage applied for part of a Flex/ Section 125 plan? ☐ No ☐ Yes - for: ☐ Life ☐ STD ☐ LTD

How are employee contributions for **LTD, STD, DBL** and/or **TDB** deducted?: ☐ Pre-Tax ☐ Post-Tax

Is other group coverage(s) **in force with Reliance Standard**? ☐ Yes ☐ No If yes, provide coverage(s) & Group #: \_\_\_\_\_

<b>Form completed by (print name):</b>  <input type="checkbox"/> Employer <input type="checkbox"/> Broker <input type="checkbox"/> G.A. /T.P.A. <input type="checkbox"/> Other: _____
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**To allow sufficient processing time, please return all submissions materials prior to requested effective date.**

<input type="checkbox"/> Self Administered ( <b>mandatory</b> 100+ lives)	<input type="checkbox"/> TPA billing: _____
We will remit premiums by: <input type="checkbox"/> Check <input type="checkbox"/> ACH Debit <input type="checkbox"/> Wire Transfer	
<b>Were you previously self-administered with your prior carrier?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, & I will use Reliance Standard's billing format If you would prefer to use your own billing format, please attach a copy for our approval & check here: <input type="checkbox"/> Yes, review my format	
<input type="checkbox"/> List Bill ( <u>by exception</u> for <100 Lives only) (census parameters on p. 1) <input type="checkbox"/> <b>Reliance Standard "Insite"</b> (special census format) _____	
<b>1st Bill Group:</b> <input type="checkbox"/> Routine Correspondent listed on Preliminary Application <b><u>OR</u></b> Billing Group Name (optional): _____ Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____ Correspondent : _____ Title: _____ Phone: _____ Fax: _____ Email: _____	
<b>2nd Bill Group:</b> Billing Group Name (optional): _____ Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____ Correspondent : _____ Title: _____ Phone: _____ Fax: _____ Email: _____	
<b>3rd Bill Group:</b> Billing Group Name (optional): _____ Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____ Correspondent : _____ Title: _____ Phone: _____ Fax: _____ Email: _____	
<i><b>If more than 3 bill groups, please supply this information on an attached sheet.</b></i>	

<b>Booklets/ Certificates</b> (n/a DBL/TDB)	<input type="checkbox"/> Electronic, provided in Adobe PDF ( <b>standard</b> )* <input type="checkbox"/> 5 ½ X 8 ½ Booklets* Proofs: available by request for 500+ lives. Include: <input type="checkbox"/> Company Logo (.tif format – 300 d.p.i) <input type="checkbox"/> Agent Name <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> 8 ½ X 11 Flat Cert's (no cover)* * Booklets are not available for SR (Travel Accident) ; flat certificates are produced.	
	<input type="checkbox"/> Same for Entire Group, combine multiple coverages (if applicable) ( <b>standard</b> ) Note: there is a maximum of 2 coverages combined per booklet; coverages cannot be combined in certificates	
	<input type="checkbox"/> by Class <input type="checkbox"/> by Coverage <input type="checkbox"/> by Affiliate	
	Mail to:	<input type="checkbox"/> Policyholder's Routine Correspondent ( <b>standard</b> ) <input type="checkbox"/> Broker <input type="checkbox"/> Other: _____ Booklet mailing instructions for multiple locations, if applicable:  Administration Kit will be mailed per above instructions unless otherwise noted.
<b>ERISA/SPD</b> (100+ employees)	Include Summary Plan Description (SPD) in addition to ERISA wording? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please provide:</b> ERISA plan number(s): Life _____ STD _____ LTD _____	
	Plan Administrator: <input type="checkbox"/> Employer ( <b>standard</b> ) <input type="checkbox"/> Union Maintaining Plan <input type="checkbox"/> Other - Administrator Name & Address: _____	
	How are Plan Records kept?: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Fiscal Year _____ <input type="checkbox"/> Policy Year (Anniv.)	
<b>Family Medical Leave Act</b>		Include FMLA coverage continuance provision?: <input type="checkbox"/> Yes <input type="checkbox"/> No (n/a for SR, STD, DBL, & TDB)

## Employee Eligibility, Service Waiting Period & Earning Definition(s)

Please select an eligibility description either for all employees (Class 1 box) **or** for each class as appropriate:

Note: All Classes standardly exclude temporary or seasonal employees.

<b>Class 1</b>	<u>Hours:</u> <input type="checkbox"/> Full-time: _____ <input type="checkbox"/> Part-time: _____ (if applicable)	<u>Includes:</u> <input type="checkbox"/> All Employees OR <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> <u>Other Description:</u>  (ie., Officer)
<b>Class 2</b>	<u>Hours:</u> <input type="checkbox"/> Full-time: _____ <input type="checkbox"/> Part-time: _____ (if applicable)	<u>Includes:</u> <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> <u>Other Description:</u>  (ie., Officer)
<b>Class 3</b>	<u>Hours:</u> <input type="checkbox"/> Full-time: _____ <input type="checkbox"/> Part-time: _____ (if applicable)	<u>Includes:</u> <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> <u>Other Description:</u>  (ie., Officer)

Other: *(Attach page listing other eligibility categories or classes, if applicable)*

<b>Employee Service Waiting Period:</b> (time employee must work before becoming eligible for insurance coverage)*	n/a	SR (Travel Acc.)
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☐ No service wait    ☐ 30 Days    ☐ 60 Days    ☐ 90 Days    ☐ 1 Month    ☐ 3 Months    ☐ Other: \_\_\_\_\_

\*For present employees covered by prior plan (on policy effective date), time employed is credited towards service wait

**Individual Effective Date:** (coverage effective date once service waiting period is complete) (see page 4 for voluntary coverage options)

☐ On the Date S.W.P. is completed    ☐ 1<sup>st</sup> of the Month coinciding with or next following S.W.P.    ☐ Other:

**Class Specific Waiting Periods(if applicable):**      Class 1:                      Class 2:                      Class 3:

**Individual Termination Date:** (see page 4 for voluntary coverage options)

☐ Employee Term. Date    ☐ 1<sup>st</sup> of Mo.   or   ☐ Last Day of Mo.   coinciding w/ or following Term. Date    ☐ Other

Reinstatement Date: (not applicable for voluntary life)

Must employee returning from an **approved** leave of absence/lay-off **re-satisfy** Service Waiting Period?

☐ No, if returning within 6 months (*standard*)      ☐ Yes    ☐ Other: \_\_\_\_\_

<b>Benefit</b>	<input type="checkbox"/> <b>1<sup>st</sup> of Month:</b> Age, Class & Earnings changes effective the <b>1<sup>st</sup> of month</b> coinciding with or next following change date
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☐ **The Date:** Age, Class & Earnings changes effective on the date of change

☐ Other:

Date \_\_\_\_\_

## Earnings Definition

Applicable to Class(es) or Coverage(s): ☐ All ☐ Other:

<input type="checkbox"/> <b>Basic Earnings Only - (standard)</b>	“Earnings”: basic salary, prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Excluding: commissions, overtime, bonuses or any other special compensation not received as basic salary.
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☐ **Basic Earnings** including - "Earnings": basic salary, prior to any deductions to a ☐ 401(k)/403(b) ☐ Section 125 plan(s).  
**Including:** ☐ Bonuses ☐ Commissions ☐ Overtime ☐ Incentive Pay  
**Averaged over** ☐ 3 years (standard) ☐ 2 years ☐ One Year (n/a for GL (Life), VAR (Vol. AD&D) or SR (Travel Accident).  
**Averaging** applies to: ☐ All Employees ☐ Salespeople ☐ Commissioned Employees ☐ Officers ☐ Other:

☐ **W2 Earnings** prior to any deductions to a ☐ 401(k)/403(b) ☐ Section 125 plan(s).  
**Including:** ☐ Bonuses ☐ Commissions ☐ Overtime ☐ Incentive Pay  
☐ Prior Year or **Averaged over** ☐ 3 years (**standard**) ☐ 2 years  
**Averaging** applies to: ☐ All Employees ☐ Salespeople  
☐ Commissioned Employees ☐ Officers ☐ Other:

**Please submit Bonus Formula Questionnaire for any definition(s) that includes bonuses.**

☐ Use **K1 Earnings** for Partners: ☐ Prior Year or **Averaged** over: ☐ 3 years (standard) ☐ 2 years

☐ Include **S Corp** wording: ☐ Prior Year or **Averaged** over : ☐ 3 years (standard) ☐ 2 years

<b>LTD, STD, DBL &amp; TDB only</b>	Claim checks to be issued to: <input type="checkbox"/> Claimant, copy Policyholder ( <i>standard</i> ) <input type="checkbox"/> Claimant <input type="checkbox"/> Policyholder
	<b>W-2's:</b> <b>LTD:</b> automatically produced <b>STD:</b> <input type="checkbox"/> by request (at additional cost – see proposal for details) <b>DBL &amp; TDB:</b> not available    (W-2's, when produced, include Employer FICA match)
	<b>Cumulative Monthly Case Summaries</b> are automatically distributed for all STD & LTD claims. <b>Quarterly Reports</b> are distributed for DBL & TDB; employer is responsible for FICA & Medicare match.
	<b>250 + lives:</b> Incl. STD/TDB/DBL telephonic claim intake? <input type="checkbox"/> No <input type="checkbox"/> Yes - will you supply eligibility feed? <input type="checkbox"/> No <input type="checkbox"/> Yes

<b>Voluntary Coverages only</b>	Completion of this form confirms agreement to implement the following Reliance Standard insurance program:	
	<input type="checkbox"/> <b>Voluntary Group Term Life</b> <input type="checkbox"/> <b>Voluntary AD&amp;D</b> <input type="checkbox"/> <b>Voluntary LTD</b> <input type="checkbox"/> <b>“VIP” Voluntary Income Protection</b>	
	<b>Eligible</b> employees to be solicited starting on _____ through _____. After enrollment, coverage will be effective _____; thereafter, future <b>eligible</b> ees will become effective: <input type="checkbox"/> 1 <sup>st</sup> of month following date application is signed <input type="checkbox"/> 1 <sup>st</sup> of the 2 <sup>nd</sup> month following date application is signed	
	<b>Payroll Deduction Mode:</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly Brochure rates <b>match</b> mode unless otherwise noted; bills will reflect <b>monthly</b> rates.	<b>Payroll Cycle:</b> Start date of first pay period: _____ End date of first pay period: _____
	<b>Rate Types:</b> <input type="checkbox"/> Tobacco Use/Non-Tobacco <input type="checkbox"/> Undifferentiated	<b>Starting Age Band:</b> <input type="checkbox"/> < Age 20 <input type="checkbox"/> < Age 30
We will prepare brochures and employee enrollment applications with the Employer's name and policy number. <i><b>Please note, payroll deductions should start immediately for all requested amounts.</b></i>		

#### Broker Information

<b>Primary Broker</b> Name (as shown on license) _____		Share % : _____
Full Address: _____		
Contact for ?s: _____ Phone: _____ Fax: _____ E-mail: _____		
<input type="checkbox"/> Individual	Individual SS #: _____	DOB: _____
<input type="checkbox"/> Corporation	Corporate Tax ID #: _____	
Information must match individual signing preliminary application for corporation:	Broker Name (as shown on license) _____ SS#: _____	
	Currently appointed with Reliance Standard in situs state? <input type="checkbox"/> No <input type="checkbox"/> Yes, Agent # _____ (if available) If no, please attach license copy. Our Licensing Dept. will provide appointment package for completion.	
<b>Additional Broker</b> Name (as shown on license) _____		Share % : _____
Full Address: _____		
Contact for ?s: _____ Phone: _____ Fax: _____ E-mail: _____		
Currently appointed with Reliance Standard in situs state? <input type="checkbox"/> No <input type="checkbox"/> Yes, Agent # _____ (if available)		
If no, please attach license copy. Our Licensing Dept. will provide appointment package for completion.		
(if applicable) <input type="checkbox"/> G.A. <input type="checkbox"/> T.P.A.		Tax ID #: _____
Agreement already on file with Reliance Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Contact for questions: _____		Phone: _____

Additional Comments or Special Instructions: