

SISLink™

New Business Transmittal Checklist

1. *New Business Submission Form - Form # SISLink™ NBSF (12/02)*
2. *Employer Application – Form #01027
(three page form - must be completed by agent with employer’s signature on the 2nd page and employer’s initials and date on the 3rd page)*
3. *Single Case Agreement*
4. *SISLink™ Applicant Information forms - Form #A-01026 (these forms may be state specific; please make sure the proper form is completed)*
5. *Copy of the Schedule of Benefits of the Primary Major Medical Plan*
6. *First month’s check made payable to Special Insurance Services*

_____ *Check Number*

_____ *Check Amount*
7. *Requested Effective Date* _____
8. *Effective Date of Major Medical Plan* _____
9. *Effective Date of Individual Coverage under Major Medical Plan (check one):*
 1st day of month following end of waiting period
 1st day immediately following end of waiting period
10. *Agent Appointment Forms and appropriate fee, if necessary (fee should be payable to Fidelity Security Life Insurance Company)*
11. *Please mail all New Business Submission materials to:*

Raymond H. Gann, Inc.
109 East Main
Whitesboro TX 76273
Attn: Ray Gann

903-564-6472 phone
903-564-1529 fax
rgann@dillardandgann.com

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.

Employer Application

SISLink™

Special Insurance Services, Inc.

6509 Windcrest Drive, Suite 200

Plano, Texas 75024

(972) 788-0699 (800) 767-6811

Fax: (972) 960-0377

Policy No. MG-100; M-9054E

Application is hereby made by:

(full name of organization/firm)
Type of Business _____
Located at _____
Number Street
City State Zip
E-Mail Address _____

Underwritten by Fidelity Security Life Insurance Company

1 Insurance shall be:
Employee Only Cost: _____ % Employer Contribution _____ % Employee Contribution
Dependent Cost: _____ % Employer Contribution _____ % Employee Contribution

2 Total number of employees: _____ *Eligible employees (including owners, partners, and executive officers) are defined as those who are engaged in their regular and customary activities (at least 20 hours per week), and not confined at home or in a hospital or medical institution*
Number of employees eligible for this plan: _____
Number of employees participating: _____
Percentage of participating employees: _____ %
Number of dependents to be covered: _____

3 In-Hospital Plan of benefits requested for all employees: Plan I: \$ _____ Plan II: \$ _____
 \$500 \$1,000 \$1,500 \$2,000 \$2,500
 \$3,000 \$3,500 \$4,000 \$5,000 Other _____
Outpatient Benefit: OPI OPII: Plan I: \$ _____ Plan II: \$ _____
 \$200 \$500 \$1,000 \$2,000 Other _____
Physician Benefit Plan I: \$ _____ Plan II: \$ _____
 \$15 visit up to the lesser of \$120 or 8 visits per family, per Calendar Year
 \$20 visit up to the lesser of \$240 or 12 visits per family, per Calendar Year
Wellness Rider Plan I: \$ _____ Plan II: \$ _____
 \$100 \$200 \$500
Outpatient Prescription Drug Benefit Rider: Generic Generic/Brand: Plan I: _____ Plan II: _____
Term Life and AD&D Rider Plan I: \$ _____ Plan II: \$ _____
 \$5,000 \$10,000 \$15,000 \$20,000

4 Billing Method: Monthly List Bill (First Month Premium is due at time of application)

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.)

Mail Premium Notice to: Employer Third Party Payor*

*Third Party Payors must be pre-approved by Home Office. A letter from the employer must be submitted with the business requesting that their billings be sent to the Third Party Payor. The Third Party Payor must also sign a Privacy Non-Disclosure Agreement.

Third Party Payor: _____

Mailing Address: _____

Contact Person/Title: _____

Copy Agent in on all correspondence? Yes No If No, all correspondence will be handled directly with the Employer.

The effective date of this insurance applied for will be the later of the first day of the month following the acceptance of employee Enrollment Forms by the Company and receipt of premium payment, or the Employee's effective date under the Employer's Major Medical/ Comprehensive coverage.

Requested effective date for group: _____

I understand that requests submitted to the Company for individual employee cancellation of coverage and return of premium, if any, must be signed by the employee.

Signature of Employer _____ Title _____ Date _____

Contact Person _____ Daytime Telephone No. _____

EMPLOYER AUTHORIZATION

DIRECT BILL:

Organization/Firm _____

Billing Address _____ City _____ State _____ Zip Code _____
(If different from the first page)

Employer's Signature _____

AGENT INFORMATION:

Writing Agent Name _____

Agent Address _____

E-Mail Address _____

Tax ID No. (If none, Social Security No.) _____

Commission Paid To _____

Are you appointed with Fidelity Security Life Insurance Company? Yes No
If "No", contact Fidelity Security Life Insurance Company immediately regarding appointment.

SPECIAL INSURANCE SERVICES, INC.
(Hereinafter called the Company)

SIS

SINGLE CASE AGREEMENT

This section must be completed by Agent/General Agent

<u>Agent/General Agent</u>	<u>Agent Number</u>	<u>Commission Percent*</u>
_____	_____	_____ % (New & Renewal)
Raymond H. Gann, Inc.	6760	_____ % (New & Renewal)
_____	_____	_____ % (New & Renewal)

*This should be the percentage of premium that the agent/general agent will receive as commission. Do not enter "100%" in this space.

ACCOUNT NAME: _____

OF ELIGIBLE PERSONS: _____

PLEASE READ THE REVERSE SIDE OF THIS FORM AND SIGN BELOW

(No reproductions of this form will be accepted.)

AGREED: _____ Special Insurance Services, Inc.

Signed: _____

Dated: _____

AGREED:

Agent: _____

Signed: _____

Dated: _____

Agent: _____

Signed: _____

Dated: _____

Agent: _____

Signed: _____

Dated: _____

Instructions:

The Writing Agent must complete this Agreement (both front and back) and submit it, along with the new business information, to the General Agent. The General Agent will complete the Agreement and forward it to Special Insurance Services, Inc. No agent will be paid commission until he/she is appointed by the underwriting carrier.

1. The Company agrees to pay you as full remuneration for services rendered for the production of insurance premiums, a commission as listed herein, on the premiums paid to the Company and received by the Company, and earned by the Company.
2. The commission provided herein shall not be payable after (a) the date on which you are no longer recognized by the employer as its Agent or Broker for this insurance; (b) the Department of Insurance has issued rules or adopted regulations affecting the commissions herein or necessitating the revision of such insurance (in the event of such contingency, this Agreement shall be subject to re-negotiation); (c) your ceasing to be a licensed Agent or Broker for any reason; (d) your ceasing to be an appointed Agent of the Company; or (e) your permanent or temporary loss of license for any reason.
3. The Agent/Broker shall receive compensation as specified for as long as the Company receives compensation at the same level as of the date of the execution of this Agreement, or until commission for all such policies is reduced by the Company. In the event of a reduction in the Company's income from levels applicable on the date of this contract, both parties agree that adjustments will be made accordingly.
4. This contract can be terminated by either party sending not less than 30 days written notice of such termination.

5. **PREMIUMS AND ACCOUNTING**

- 5.1 All premiums are to be paid directly to the Company. The Agent has no authority to alter, modify, waive or change any of the terms, rates or conditions of the Company's Master Policy or certificates, to collect renewal premium, to extend time for payment of premium, or to endorse checks payable to the Company.
- 5.2 The right of the Agent or any other person to receive commissions shall, at all times, be subordinate to the right of the Company to offset or apply commissions against any indebtedness of the Agent to the Company. This right of offset shall include, but not be limited to, application against any liability incurred by the Company to any person by reason of the negligent or unauthorized acts committed by the Agent or any of his sub-agents or brokers. In the event commissions due hereunder are not sufficient to satisfy the debt, the Company may require immediate repayment of the debt from the Agent. An extension of time for repayment or modification of the amount due shall not waive the Company's rights hereunder.
- 5.3 All accounting and records of the Agent pertaining to insurance written through the Company shall be subject to inspection and audit by the Company at any reasonable time.

6. **GENERAL PROVISIONS**

- 6.1 The Company shall not be responsible for any expenses incurred by the Agent whether on the Agent's or Company's behalf. The Company shall administer the program and pay for all application forms, certificates, renewal billings and reporting forms.
- 6.2 Should the Company, for any reason, refund any premium on any policy or insured enrolled by any application procured by the Agent, his sub-agent or broker, the Agent shall be liable and shall make repayment of any commission paid to the Agent for the policy or application.
- 6.3 The assignment of commission or any other funds that may be due the Agent under this Agreement is prohibited and shall not be valid unless authorized in advance in writing by the Company. Any such authorized assignment shall at all times be subject to any and all indebtedness of the Agent to the Company.
- 6.4 All notices, requests, communications and demands under this Agreement shall be in writing and shall be duly given if delivered in person or sent by registered mail, postage prepaid, to the party entitled to notice at the address which appears in the records of the Company.

Writing Agent's Initials: _____ Date: _____