

**EMPLOYER APPLICATION**

<b>Group Information</b>			
Group name & Quote # (If available)		Eligibility hours	Effective date
Group contact name	Email address	Phone number	Fax number
Address		City	State Zip code
Shipping or Mailing address (if different from above)		City	State Zip code
Billing Option <input type="checkbox"/> Hours Trust <input type="checkbox"/> Monthly	First month premium <input type="checkbox"/> All employees covered from first month <input type="checkbox"/> Hours reported (attached)	Provide HCR report? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Plans sold: (plan name)	Health plan name	Plans sold: (plan name)	Health plan name
Plans sold: (plan name)	Health plan name	Plans sold: (plan name)	Health plan name
<b>Trustee Information</b>			
Is there a trustee-to-trustee Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, who is the trustee?		Has client written a request for funds transfer? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Report available for funds expected to be transferred? <input type="checkbox"/> Yes <input type="checkbox"/> No   N/A		Group statistics: Total # of lives Total 1 <sup>st</sup> month contribution \$	
<b>Broker Information</b>			
Broker name	Agency name	Email address	
Phone number		Fax number	
Address		City	State Zip code
<b>Authorized Contact:</b>			
Print or Type Name		Title	
Signature		Date	