SISLink™

New Business Transmittal Checklist

1. ***New Business Submission Form - Form # SISLink™ NBSF (12/02)***

2. ***Employer Application – Form #A-01027***
   (two page form - must be completed by agent with employer's signature on the 2nd page

3. ***Single Case Agreement***

5. ***SISLink™ Applicant Information forms - Form #A-01026***

6. ***Copy of the Schedule of Benefits of the Primary Major Medical Plan***

7. ***First month's check made payable to Special Insurance Services***

   _________ Check Number

   _________ Check Amount

8. ***Requested Effective Date ____________***

9. ***Effective Date of Major Medical Plan ___________***

10. ***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***

11. ***Agent Appointment Forms (if necessary)***

12. ***Please mail all New Business Submission materials to:***

Special Insurance Services
6509 Windcrest Drive #200
Plano TX 75024
Attn: Marketing or Marketing Rep Name

972-788-0699 phone
972-991-3936 fax
marketing@specialinc.com

SISLink™ NEW BUSINESS SUBMISSION FORM

PLEASE FULLY COMPLETE THE ENTIRE FORM, FRONT AND BACK, TO AVOID ANY PROCESSING 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

Underwritten by Fidelity Security Life Insurance Company

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

1 Insurance shall be:

Employee Only Cost: ______% Employer Contribution ______% Employee Contribution
Dependent Cost: ______% Employer Contribution ______% Employee Contribution

2 Total number of employees: ______________
Number of employees eligible for this plan: ______________
Number of employees participating: ______________
Percentage of participating employees: ______________%
Number of dependents to be covered: ______________

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

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 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

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 ____________________

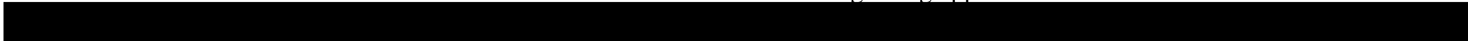
Agent Address ____________________

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.



Policy No. MG-100; M-9054E

Application To:
Fidelity Security Life Insurance Company
3130 Broadway, Kansas City, MO 64111-2406

FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE

SISLink™

Arranged by:
Special Insurance Services, Inc.
6509 Windcrest Drive, Suite 200
Plano, TX 75024

PLAN INFORMATION:

As selected by the Policyholder

		In Hospital Benefit Amounts
☐ Plan I:	$ ______	In-Hospital Benefit
	$ ______	Optional Out-Patient Benefit
	$ ______	Optional Physician Benefit Rider
	$ ______	Optional Wellness Rider
☐ Plan I:	$ ______	In-Hospital Benefit
	$ ______	Optional Out-Patient Benefit
	$ ______	Optional Physician Benefit Rider
	$ ______	Optional Wellness Rider

APPLICANT INFORMATION:

Name (last, first, middle)				Sex ☐ M ☐ F
Age	Date of Birth (mm/dd/yy)	Social Security Number	Home Phone #	Work Phone #
Street Address			E-Mail	
City		State		Zip Code
Employer		Occupation		Date of Hire
Coverage Selected:	☐ Employee Only ☐ Employee & Child(ren)		☐ Employee & Spouse ☐ Employee & Family	
Monthly Premium:		Requested Effective of Coverage/Change:		

DEPENDENT INFORMATION:

	Name (last, first, middle)	Birth Date	Sex	Social Security #
Spouse				
Child				
Child				
Child				

(Use reverse side of form if additional space is needed)

I hereby: ☐ **ENROLL**, or ☐ **CHANGE** as indicated above, for this group insurance coverage for which I am eligible. I authorize my Employer to deduct my contributions, of any, from my salary or wages, and to remit that amount to Fidelity Security Life Insurance Company. I request that this authorization remain in effect until such time as I withdraw it by giving written notice prior to the next premium due date. I understand and acknowledge: that no coverage will take effect for any person to be covered who is not also covered by a Major Medical/Comprehensive Policy including Coinsurance and Deductible, in force at the time of my proposed Effective Date for this coverage; that I am either currently covered under a Major Medical/Comprehensive coverage with this Employer or have enrolled for Major Medical/Comprehensive coverage with this Employer; that the coverage for which I am applying may contain Pre-Existing Limitations; that the Master Policy for this coverage is issued to my Employer; and that I will receive a certificate as evidence of my insurance coverage under the policy.

Applicant's Signature ______________________ Date ____________
Parent or Legal Guardian if the Applicant is under age 18

Agent's Signature (where applicable by law) ______________________

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

SIS

SINGLE CASE AGREEMENT

This section must be completed by Agent/General Agent

Agent/General Agent	Agent Number	Commission Percent*
______________________	__________	_______ % (New & Renewal)
______________________	__________	_______ % (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: ______________