List Bill/Group Information

Worksite Addendums are required along with a complete application for each employee. All pages are required.

- **Addendums:** Complete The Premium Payment Agreement and the New Business Transmittal For Worksite. There should be a total of 6 pages. If you are going to enter the group through Manhattan Direct, these pages must be submitted for set up prior to inputting any of the applicant's information. Set up takes 1-2 business days and you will be notified via email that your site is ready to receive your applications. If you are submitting paper apps, you only need to submit one set of the addendums with your group applications.
- **Effective Date:** If the Requested Effective Date is less than 30 days out, you will be required to collect the first premium or a copy of a Void check. If the Requested Effective Date is more than 30 days out, the initial premium may be direct billed. Please be advised that BMC Agency, Inc. does not handle physical payments. If you collect a physical payment, you must mail it direct to Manhattan Life.
- **Agent Statement:** The employer must sign this section as the Payor for each applicant.
- **Premium Deduct Authorization:** Because this is a List Bill/Group, on the bottom of page 2, the employee is required to sign the Premium Deduction Authorization to the Employer section *instead* of the Bank Draft Authorization to Honor Checks section.
- **Products:** The employees may choose any HI plans, Cancer plans, and/or Accident plans. The plans in the List Bill/Group **DO NOT** have to all be the same.

- **Submitting Your Group:** Please submit all of the applications and your transmittals to me via email. Mail. Or fax. Please see my information below.

If you have any questions, please contact me.

Christi Byrd
c/o BMC Agency, Inc.
1529 Sam Rittenberg Blvd Ste 200
Charleston, SC 29407

1-800-357-2342 ext 102
FAX: 843-763-1602
christibyrdbmc@gmail.com

● ManhattanLife Assurance ● Family Life ● Manhattan Life
10777 Northwest Freeway, Houston, TX 77092
Telephone: (713) 529-0045 Toll Free: (800) 669-9030

❑ Initial Enrollment
❑ Re-enrollment

WRITING AGENT INFORMATION		
Agent Name (Last, First, Middle Initial)	Agency	Agent Number
Contact Phone Number	Email	Fax Number
Address		

APPLICATION SUBMISSION		
❑ Paper	❑ Manhattan Direct	❑ WISE (Online Group Enrollment)
MAIL POLICIES TO		
❑ Insured	❑ Employer	❑ Agent
GROUP EFFECTIVE DATE		

COMPANY INFORMATION		
Company Name		
Phone Number	Industry	
Address		
GROUP ADMINISTRATOR INFORMATION		
Name	Phone	Email
Total Number of Employees	Location of Employees (State)	
How many employees are eligible for benefits? _____		

COVERAGE DESIRED

If group is requesting special enrollment provisions, approval is required prior to enrollment (circle the corresponding special enrollment provision number next to the applicable product):

1. Credit for time served
2. Waive pre-existing condition
3. Waive waiting period (takeover)
4. Guaranteed issue

❑ Accident-PAID ❑ Affordable Choice ❑ Cancer	❑ Hospital Indemnity ❑ DVH ❑ FOB ❑ GAP	❑ Group DI 1 4 ❑ Individual DI 4 ❑ Voluntary Group Term 4	❑ Accident-EXPRESS 3 4 ❑ Cancer-EXPRESS 1 3 4 ❑ GAP-EXPRESS 1 2 3 4

1. What states will products be offered in? _____
2. Will all products selected be offered in all states? ❑ Yes ❑ No
3. Will the employer contribute to any portion of the premium? ❑ Yes ❑ No
   If "Yes," which product(s), and how much of a contribution? ❑ Dollar Value _____
   ❑ Percentage _____

CURRENT INSURANCE (if applicable)	
Current Carrier	Type of Coverage
Number of Employees Covered	Effective Date of Coverage

PREMIUM PAYMENT

Date Initial Deductions Will Begin:

Deduction Frequency:

❑ Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly ❑ Other _____

Are you currently in a payroll deduction group with MAC, FLIC, or MLIC? ❑ Yes ❑ No

If "Yes," which company _____.

CAFETERIA PLAN (SECTION 125)

Please answer the following questions, so we may properly set your account up and not cause any delays in processing:

1. Does your company currently have a Section 125 Cafeteria Plan in place? If "No," skip questions 2-4. ❑ Yes ❑
2. The Company's 125 plan year is _____ through .
3. Are the premiums to be sheltered under a Cafeteria Plan? ❑ Yes ❑ No
4. Open enrollment period is held during the month of .

Enrolling Company Name	Home Office City	State
Signature of Officer	Title	Date

ManhattanLife Since 1850

MANHATTAN INSURANCE GROUP
New Business Transmittal for Worksite

This transmittal is needed for administrative and system purposes. Thank You.

P L E A S E P R I N T

Agent: _____

Deposit Check Amount $ _____ Check # _____

Group # (Assigned by CUL): Group Effective Date:

GROUP INFORMATION

1. Full Legal Name: _____
(Check employer application for group's full legal name).

Mailing Street Address: _____
(Must have street address for shipping of certificates by UPS).

City: _____ State: _____ Zip: _____

2. Subsidiaries Included: No Yes If yes, list full legal name(s) on a separate sheet.

3. Type of Business:

4. Contract will be issued in the State of _____

5. Person to receive Welcome Letter:

Name: _____

Title: _____

Phone #: _____ Fax #: _____

Emailaddress: _____

Address (if different from above):
_____

6. Administrative Contact at employer: (if same as item 5 check box)

Name: _____

Title: _____

Phone #: Fax #: _____

Emailaddress: _____

Address (if different from above):
_____

GROUP POLICY & ELIGIBILITY INFORMATION

1) Mail agent certificates and master policy to:

Agent
Employees (home office list bill groups only)
Administrative Contact for Group
Other _____

2) If employer has more than 1 class of eligible employees, does the employer want separate benefit booklets for each class? No ☐ Yes ☐ If Yes, indicate number of employees by class:

Class 1: _____ Class2: _____ Class 3: _____

3) Number of Eligible Participants: _____

4) Number of Plan Participants enrolled by coverage:

Hospital Indemnity
Basic Care _____ Voluntary Group Term _____

Group DI _____ Group Accident _____

Vision _____ Dental _____

5) Employees must work _____ hours per week to be considered eligible.

ERISA INFORMATION FOR BASIC CARE, VISION, DENTAL, AND GROUP LIFE

All groups subject to ERISA **must** complete the information below which will be included in the policy and booklets.*

1. Name of Plan (exact legal name of Plan): _____

2. Employer Identification Number: _____

3. Name and Address of Agent for Service of Legal Process (if different from Employer): _____

4. Plan Year Ends (month/day): _____

5. Name and Address of Plan Administrator (if different from Employer): _____

Groups not subject to ERISA must provide legal proof of exemption.
Exempted groups are: Government plans, Church plans, plans maintained solely to comply with workers' compensation, unemployment compensation or disability insurance laws and unfunded excess benefit plans. Groups should check with their legal advisor for details.

COMMISSION INFORMATION

IMPORTANT NOTE: All individuals or corporations must be appointed to sell CUL products. Contact us at 800-669-9030 if you need an appointment packet.

1. Service Agent or Agency: _____
2. Agent solicited business? _____
3. Service Agent Email address: _____ Phone: _____
4. Commissions payable to:
   Name of Agent or Agency

   _____ SS# or Tax ID#: _____

Coverage	**Commissions**
Hospital Indemnity	
Basic Care	%
Group Accident _____	%
Voluntary Group Life _____	%
Short Term Disability _____	%
Dental _____	%
Vision	%

5. Commissions payable to:
   Name of Agent or Agency

   _____ SS# or Tax ID#: _____

Coverage	**Commissions**
Hospiotal	
Basic Care IndemnityIn	%
Group Accident	
Indemnity _____	%
Voluntary Group Life _____	%
Short Term Disability _____	%
Dental _____	%
Vision	%

SOLD RATE INFORMATION

DISABILITY CLASS _____

Waiting periods and duration _____

GROUP ACCIDENT PLAN

Attach Group Accident rates on separate sheet.

BASIC CARE Hospital Indemnity

Indicate the Basic Care Plans Sold: _____

The following MUST be included with a new sold case.

1. Completed and signed ***original*** employer application. (copies or faxes are **NOT** accepted.)
2. Deposit check.
3. Completed employee enrollment forms.
4. Sold rate confirmation, proposal or quote information.
5. This new business transmittal.

Submitted by: _____Date: _____

Submit to:

BMC Agency,
Inc. Attn: Christi
Byrd
1529 Sam Ritteberg Blvd., Ste.
200 Charleston, SC 29407
843.763.1602 FAX
christibyrdbmc@gmail.com