Leaders Life Insurance Company

# Group Setup Form

All policies are mailed directly to employee/member.
Email all information to policyservice@leaderslife.com, or upload through our Broker Portal on Leaderslife.com

**Date Submitted:_____ New groups and re-enrollments - complete ALL sections.**

## Section 1 - Employer Information

Full Legal Name of Business:_____ SIC Code:_____
Tax ID: _____ Business Industry/Classification:_____
Business Contact:_____ Email:_____
Phone Number:_____ Fax Number:_____
Business Address:_____
Billing Contact:_____ Email:_____
Billing Address:_____
Is Billing Contact a TPA? ☐ Yes ☐ No If yes, Name of TPA: _____
Total Number of Employees:_____ Number of Full-time Eligible Employees: _____

## Section 2 - Enrollment Information

Open Enrollment Period: From:_____ To: _____ Effective Date*:_____
*First Bill Date will be the Effective Date.

## Section 3 - Billing Information

Billing Preference: ☐ Paper ☐ Online (PDF or CSV available)
Payroll Deduction Frequency (choose one): ☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly
Remittance Frequency (choose one): ☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly
Groups with multiple locations: Are locations billed separately*? ☐ Yes ☐ No
*If yes, provide a separate setup form for each location. If no, provide location names in section 7.

## Section 4 - Desired Underwriting

**Lifetime Term to 100: Choose One Only:**
☐ Full Contingent Issue - $100,000
☐ Reduced Contingent Issue - $25,000
☐ Simplified Issue -Max $150,000

**CI Underwriting for Term to 100:**
- All current employees, existing and new hires, are eligible to apply for CI Coverage during the Initial open enrollment period.
- After initial enrollment, new hires can qualify for CI Underwriting within 90 days of their hire date.

**Group Term to 120:**
☐ Guarantee Issue
☐ $25K employee ☐ $30K employee
☐ $35K employee ☐ $40K employee
☐ $45K employee ☐ $50K employee

☐ Approved Proposal Amount

**GI Underwriting for Term to 120:**
- Face amounts greater than $50K require prior approval.

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# Group Setup Form

## Section 5 - Product Information

**Shelf-rated Plans**

☐ **Lifetime Term to 100**

**Select one (If offering)**

☐ Chronic Condition Rider
☐ Critical Illness Rider

**Select all that apply**

☑ Spouse Rider ☑ Child Rider
☑ Accidental Death Benefit Rider

☐ **Secure Group Accident Plan**
(indicate levels offered -maximum of 2)
☐ Base ☐ Advantage ☐ Elite ☐ Premier

☐ **Individual Wage Protector**
Occupation Class_____

**Check All that Apply:**

Elimination Period(s):
☐ 7/7 ☐ 0/7 ☐ 14/14 ☐ 0/14 ☐ 30/30 ☐ 0/30 ☐ All

Benefit Period(s):
☐ 13 wks ☐ 26 wks ☐ 52 wks ☐ 104 wks ☐ All

**If this product is replacing a group sponsored short-term disability, you must include a copy of the current bill that includes the name of prior carrier and effective date for policies being replaced to secure pre-ex credit.

**Quoted Plans -** Census and signed proposal required

☐ **Group Term to 120**

**Select one (If offering)**

☐ Chronic Condition Rider
☐ Critical Illness Rider

**Select all that apply**

☐ Spouse Rider ☐ Child Rider
☐ Accidental Death Benefit Rider

☐ **Employer Paid Group Term Life**
(Basic Life with AD&D coverage)

☐ **Group Short-Term Disability**

☐ Employer Paid ☐ Voluntary

- Is this replacing another group sponsored short-term disability plan? ☐ Yes ☐ No
  **If yes, to secure pre-ex credit, must include a copy of the LATEST bill that includes the name of the prior carrier and effective dates for policies being replaced.
- Does the group offer a Long-term Disability plan? ☐ Yes ☐ No
- If yes, what is elimination period? _____ months
  What is the % of salary?_____
- Does the group offer a salary continuation or extended sick leave plan? ☐ Yes ☐ No

## Section 6 - Agent of Record

Primary Agent/Agency of Record: _____

| Writing Agent Name(s) | Agent ID | Commission Split |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Section 7 - Additional Locations

_____

_____

_____

For Internal Use Only: ☐ LLIC ☐ BBA ☐ DIS

Leaders Life Insurance Company
1350 S Boulder, Suite 900
Tulsa OK 74119

Leaders Life Insurance Company

# Voluntary Insurance Programs Payment Agreement

This Agreement sets forth the terms of Employee payments and Employer payments as well as payroll deductions for insurance premiums to be pay to Leaders Life Insurance Company. It is agreed that the Employer will make payroll deduction of premiums as authorized by Employees and promptly forward the aggregate sum thereof and/or remit Employer paid payments to Leaders Life Insurance Company. The date for monthly remittance shall be the day of each month, agreed upon by the Employer and Leaders Life.

The Employer bears no liability, responsibility, or obligation for the Employee's insurance or for the late payment of premium except as provided herein. Employer agrees from the date of payroll deduction, the sums withheld are the property of Leaders Life Insurance Company, and the Employer holds such amounts as a fiduciary of Leaders Life Insurance Company with the sole obligation of remittance.

If the Employer desires eligibility requirements or special billing based on location, etc., then the appropriate information such as salary, location code, payroll type, etc. will also be required.

Leaders Life agrees to furnish a monthly statement indicating the premium due by each participating Employee. Employer agrees to make remittance by the due date on the statement. If payroll deducted premiums, and/or Employer paid premiums are not remitted as stated in this agreement, Leaders Life reserves the right to terminate this agreement with the Employer and to terminate the insurance of the Employee immediately. Employer also agrees to promptly notify Leaders Life of the name of any participating Employee who leaves its employment, withdraws a Salary Deduction Authorization or for whom payment will not be made. Employer agrees to remit all funds withheld from the Employee, and/or Employer paid premiums through the date of termination to Leaders Life and discontinue future payroll deductions upon termination. Payroll deductions withheld after the termination of benefit(s) are not the responsibility of Leaders Life and must be returned by the Employer to the Employee. With regard to re-hiring of former Employees, Employer must contact Leaders Life Home Office for guidelines prior to resuming payroll deductions, and/or resuming Employer paid payments.

If Employer terminates this agreement by 30 days written notice to Leaders Life Insurance, Employer will be fully discharged upon remittance of premiums deducted.

By execution of the agreement, the Employer pledges its full support and cooperation.

***An eligible employee is defined as a permanent, full-time, W-2 employee of the company who works a minimum of 20 hours per week. The term does not include independent contractors, volunteers, interns, temporary workers, or other individuals who are not employed by the organization on a regular or ongoing basis. Note that eligibility is subject to each plan's state specific requirements.***

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☐ Payroll Deducted Program ☐ Employer Paid Program

Date: _____ _____
Name and Title of Person to Receive Billing

Employer: _____ _____
Employer Address

By: _____ _____
Name and Title of Authorized Officer Number of Eligible Employees

Signed: _____ _____
Signature of Authorized Officer Signature of Agent of Record

Leaders Life Insurance Company

**Leaders Life Insurance Company**
[P.O. Box 35768, Tulsa, OK 74153]
1 800-725-5433

## POLICYHOLDER APPLICATION FOR GROUP TERM to 120 LIFE INSURANCE

### POLICYHOLDER INFORMATION

| | | | |
|---|---|---|---|
| Proposed Policyholder (Full Corporate/Legal Name) | | Proposed Effective Date (subject to approval by Leaders Life): | |
| | | | |
| Mailing Address (Number/Street/City) | | State | Zip |
| Contact Person | Telephone ( ) | Email Address | |
| Name of Business | | Location(s) | |
| State of Incorporation (the laws of the State of Incorporation will govern the Policy) | | | |
| Description of the Type of Business | | Years in Existence | SIC/NAICS Code (if available) |
| Will the proposed insurance replace or act to change any existing group insurance? ☐ Yes ☐ No | | Tax I.D. Number | |

| Classification | Description of Eligible Insureds | # of Eligible Insureds | Minimum Face Amount | Maximum Face Amount |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

| | | |
|---|---|---|
| % of Premium Paid by:<br>Policyholder % Insured % | Total Number of Eligible Insureds: | Annual Open Enrollment Period:<br>Month of _____ |

Waiting Period for Coverage:
An Eligible Insured must be Actively at Work for _____ days before applying for coverage.

Initial Enrollment: Start Date:_____ Stop Date: _____
Initial Plan Effective Date:_____ Waiting Period (if any) _____ Days

Base Plan - Lifetime

Accelerated Benefit Included:
- ☐ 60% Chronic Condition (Employee Only)
- ☐ 30% Critical Illness (Employee Only)
- ☐ No Accelerated Benefit Rider

Employee Accident Benefit Rider:
- ☐ Accidental Death Benefit (Employee Only)
- ☐ No Employee BenefitRider

Dependent Riders being offered:
- ☐ Spouse Term Rider (STR)
- ☐ Child Term Rider (CTR)
- ☐ No Dependent Coverage

Leaders Life
Insurance Company

## BILLING INFORMATION

Deduction Method/Payroll Frequency:

☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other_____

Billing Frequency:

☐ Monthly ☐Other_____

## AGREEMENT

**IT IS UNDERSTOOD AND AGREED THAT**

1. The Group Policy will become effective on the Proposed Effective Date shown above only if this application is accepted at the Home Office of Leaders Life Insurance Company, and;
2. The conditions of eligibility, the insurance coverage, benefits and amounts, the conditions under which the benefits will be payable and all other terms and conditions of this insurance will be in accordance with the Group Policy issued, and;
3. Any certificates, amendments, riders, endorsements, thereto which together with the copy of this application attached to the Group Policy and the individual application(s) of the persons to be insured, will constitute the entire contract, and;
4. This policy does not provide major medical or comprehensive health insurance coverage, and does not take the place of such insurance.

**Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

**SUBMITTED FOR PROPOSED GROUP POLICYHOLDER**

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for Leaders Life Insurance Company Group Term Life Insurance; and the proposed Policyholder understands and agrees that the Policyholder and the Covered Persons shall be subject to the provisions set forth herein.

| | |
|---|---|
| | On: (Mo/Day/Yr) At: (City/State) |
| (Name/Title) | (Signature) |
| (Agent Name/Agent No.) | (Signature) |