



Request for Group Insurance

CNA Group Benefits
 40 Wall Street, 10th Floor
 New York, NY 10005
 (212) 440-2447
 Fax (212) 440-2423

To facilitate the processing of your policy(ies) please ensure all information is complete and accurate.
 If you have any questions please contact your CNA Sales Representative.

POLICYHOLDER INFORMATION: PLEASE TYPE EXACTLY AS IT SHOULD APPEAR IN THE CONTRACT				
Policyholder's Legal Name:				
Street Address:			City	State
Zip Code		County		
Telephone Number: () -	Fax Number: () -	Employer Federal Tax ID Number (Required):		
Nature of Business (Please be specific):			E-mail Address:	
Policyholder Contact Name: <input type="checkbox"/> Mr., <input type="checkbox"/> Ms.	Last:	First:		
Are Subsidiaries/Affiliates to be covered? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide a list of complete names and addresses of all subsidiaries/affiliates to be insured.				
Type of Organization: <input type="checkbox"/> Corporation, <input type="checkbox"/> Partnership, <input type="checkbox"/> Sole Partnership, <input type="checkbox"/> Subchapter S Corporation, <input type="checkbox"/> Other _____				
Do you employ Foreign Nationals (including Canadians), Resident Aliens or U.S. Expatriates? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please provide list including names and locations of each Foreign National, Resident Alien or U.S. Expatriate you employ on a separate page. Note: Marking "yes" does not constitute automatic coverage. <u>Foreign National</u> – Individual who is not a U.S. citizen and not working in the United States. <u>U.S. Expatriate</u> – U.S. citizen living and/or working outside the United States. <u>Resident Alien</u> – Individual who is not a U.S. citizen but has been granted the legal right to live and work in the United States.				

BILLING INFORMATION		
Will there be more than one billing location? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide a list of company names, addresses and employees at the individual billing locations.		
Bill should be sent to: <input type="checkbox"/> Account, <input type="checkbox"/> Producer, <input type="checkbox"/> TPA, <input type="checkbox"/> Other (please complete information below)		
Company Name:	Billing Address: (if different from Policyholder or Producer addresses)	
Contact Name:	Telephone Number: () -	Fax Number: () -
Choose one billing format type: Volume Billing <input type="checkbox"/> (Self-adjusting), *List Billing <input type="checkbox"/> (Itemized statement), Direct Billing <input type="checkbox"/> (Group Travel only) *List billing – (1) Required on contributory cases with less than 101 eligible lives. (2) Additional cost for non-contributory cases [101-499 lives] requesting List Billing, (3) Not available on any case over 500 lives. List billed cases require an employee census with the following information: Name, Date of Birth, Social Security Number, Gender, Annual Salary, Date of Hire, Class Designation, all Benefits Elected and Benefit Amounts. Census information should be forwarded via email or diskette, preferably in Excel or Lotus format.		

ERISA - SUMMARY PLAN DESCRIPTION (SPD) INFORMATION		<input type="checkbox"/> Not Applicable/Employer will provide SPD
Plan Name:	Plan Sponsor:	
Plan Administrator: (if different from the Plan Sponsor)		
Plan Number: (Ex. 501) Life, STD, LTD, AD&D	Employer Tax ID Number:	
How are fiscal records for the plan maintained? <input type="checkbox"/> Calendar Year <input type="checkbox"/> Policy Year <input type="checkbox"/> Fiscal Year	If other than calendar year, what is the last day of the policy or fiscal year?	



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PREMIUM TAX DISTRIBUTION <input type="checkbox"/> Not Applicable
If applicable, this information must be presented before policy will be issued
State Percentages: (applicable to All States) If you have 500 insured employees or more please list percentage of insured employees in each state of residence.
Municipality Percentages: (applicable to AL, KY LA, MO & SC only) If you have 500 insured employees or more please list percentage of insured employees in each state and municipality of residence.

CERTIFICATE FORMAT INFORMATION	
If two or more classes are eligible, would you prefer separate certificates for each class? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how would you like the certificate covers to read?	
Print producer address information on the back cover of the certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No Include producer's phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please select *ONE of the following options:	If you elected printed documents please complete this section:
<input type="checkbox"/> Printed policy documents <input type="checkbox"/> **CNA DocsNow! policy documents	Forward <u>printed</u> documents to: <input type="checkbox"/> Policyholder <input type="checkbox"/> Producer
*If both printed and on-line document are requested, a \$0.75 /certificate charge will apply to all printed certificates.	
**CNA DocsNow! is a customized, password-protected web site that posts your documents (policies, administration manual and certificates) as read-only files, which can be viewed and printed using Adobe Acrobat reader. The site also contains links to CNA sites containing enrollment and claim forms as well as elements requested by you, such as your logo and links to Internet information sites. By electing this service, you will be able to give your employees the flexibility to access and manage their benefits via the Internet anytime, 24 hours a day, seven days a week, at work or at home.	
If you elected CNA DocsNow! please complete the following information:	
Do you want to include your corporate logo on the web site? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide your logo via diskette, email (jpg or gif format) or we can copy it from your company web site. Website Address:	
CNA DocsNow! website links. The CNA DocsNow! website will automatically be linked to the main CNA site, CNA Group Benefits site, CNA forms site, and Adobe Acrobat® site. If you wish to eliminate one of these links please note:	
If you would like to include your Company's web site and/or other web sites, maximum of three additional sites, please complete below.	
Website Name: _____	Website Address: _____
Website Name: _____	Website Address: _____
Website Name: _____	Website Address: _____

ACTIVELY AT WORK INFORMATION
Do you have any eligible employees who are not currently "Actively At Work" due to injury or sickness?
<input type="checkbox"/> yes <input type="checkbox"/> no If yes, please attach separate sheet with employee's name and an explanation of condition(s)

SIGNATURE REQUIREMENTS		
Employer Representative Name:	Employer Signature:	
Title:	Date:	Telephone Number:
Producer Representative Name:	Producer Signature:	
Title:	Date:	Telephone Number:

This is a request for coverage only. Coverage is not effective until bound by Continental Casualty Company /Continental Assurance Company/Group Life Assurance. All data included must be complete and accurate, as it will be used to generate the policy and the booklet certificates.