



Client Information

Legal Name of Entity: *(This information must match name on the application - it is very important you include appropriate punctuation and any abbreviations applicable, as it should appear on booklets.)*

Legal Address: _____
(booklets cannot be delivered to a P.O. Box)

City _____ State/Province _____ ZipCode _____

Effective Date of Case _____ Tax Identification Number _____

Nature of Business *(please specify)* _____ Number of Years in Business _____

Does this plan replace other coverage? No Yes
(If yes, attach a copy of the prior carrier's contract or booklet.) Name of Prior Carrier _____

State/Province of Jurisdiction *(where the corporate headquarters is located)* _____

Are other divisions, subsidiaries, or affiliates covered under this plan? No Yes
If yes, attach list to include company name, city, state, and zip code.
If yes, relationship _____ Nature of Business _____

Case/Claim Contact: _____ Title _____
Address: _____
Telephone Number _____ Fax Number _____
E-Mail Address _____

Bill Contact: *(if different from above please indicate)* _____
Address: _____
Telephone Number _____ Fax Number _____
E-Mail Address _____

Billing Information:
List Billed? _____ *(census must include Name, SS#, DOB, DOH, Salary, Occupation & Class # if applicable)*
or Self Administered? _____

Description of eligible employees: *(i.e., "All Active Full-Time Salaried Employees)*

Number of eligible employees _____ Are any employees excluded? No Yes
If yes, who _____

Minimum number of hours the employee must work to be covered _____ **(30 Hours Standard)**

Type of Organization

Corporation	Trust	Partnership	Non-Profit	Sole Proprietor	School District
Municipality	Limited Partnership	Union Group	LLC	Proprietorship	

Does the company have a fully funded retirement plan? No Yes
 Does the company have an extended sick leave or salary continuation program? No Yes
 If yes, how long is it? _____

Are U.S. employees in other states or countries covered? No Yes – If yes, List employees by State & Country
 Are foreign nationals covered under this plan? No Yes - If yes, List employees by State & Country

ERISA: No Yes If yes, please include Plan Number: _____ Plan Year: _____
 Is this part of an Employee Welfare Plan?: No Yes Is this part of a Cafeteria Plan? No Yes

Waiting Period:

Original Employees: *If an employee is still satisfying the waiting period under the Prior Plan, does the employer want time served under the prior plan to count towards the satisfaction of the waiting period of the Hartford plan? If so, the original waiting period should match that of new employees.*

- On the policy effective date (none).
- After _____ of employment.
- 1st of the month coinciding w/ or next following _____ of active employment.
- 1st of month following _____ of employment.
- 1st of month following date of hire.
- Other (*not applicable if list bill case*) _____

New Employees:

- On the policy effective date (none).
- After _____ of employment.
- 1st of the month coinciding w/ or next following _____ of active employment.
- 1st of month following _____ of employment.
- 1st of month following date of hire.
- Other (*not applicable if list bill case*) _____

Annual Enrollment Period: No Yes (If yes – Dates: From _____ To _____
 Effective date of change: _____)

Contributions:

The employer pays 100% of the cost The employee pays 100% of the cost
 Both the employer & employee pay for the plan; if yes, percentage employer contributes: _____ %
 percentage employee contributes: _____ %
 Are premiums employees pay deducted from pre-tax salary? No Yes

Basic Monthly Earnings

Please check one:

Salary Only Salary & Commissions Salary & Bonuses Salary, Commissions & Bonuses
 If commissions included (LTD only): Prior Year W2 Earnings Average 1yr Average 2yrs Average 3 yrs.
 For K-1 Partners Income (**circle one**): Tax Year (or) Calendar Year
Is Deferred Compensation to be included with above definition? No Yes
 Other, please specify _____
 If earnings differ by employee group(s), class(es) or division(s), please specify difference.

Confirm Sold Coverage(s) & Rate(s) – Check all that apply

LIFE: Rate: _____ SUPP: Rate: _____ LTD: Rate: _____

AD&D: Rate: _____

DEP: Rate: _____

STD: Rate: _____

Completed by: _____

Date: _____