



Northwest Marketing Resources, Inc

## **New Business Checklist for**

### **FDI Group – Security Life Voluntary Dental**

- \_\_\_\_\_ Master Application Completed and signed by Officer of Corporation. Dental and/or Vision.
- \_\_\_\_\_ Employee Apps for Vision only GHA-1157E and Dental & Vision use form #GHA-1164.
- \_\_\_\_\_ Check for first months premium made payable to Financial Design, Inc (or FDI, Inc.) include \$10.00 monthly billing fee.
- \_\_\_\_\_ We must have the case by the last day of the month proceeding the requested effective date.
- \_\_\_\_\_ If we are replacing prior coverage include a copy of the most recent billing statement along with a copy of the policy.
- \_\_\_\_\_ You must be appointed with Security Life.
- \_\_\_\_\_ Mail all completed forms to: Northwest Marketing Resources  
PO Box 447  
Olympia, WA 98507
- Street Address: 522 Franklin St. SE  
Olympia, WA 98501

**EMPLOYER PARTICIPATION APPLICATION**

The Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under the Policy, GH-1112-37780, based upon the following statements and representations. The Employer must select the coverage and pay the required premium. Those eligible will be covered as described in this application.

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_

Direct All Communications to (Name) \_\_\_\_\_ (Title) \_\_\_\_\_

Nature of Business: \_\_\_\_\_ Company Organized Month \_\_\_\_\_ Year \_\_\_\_\_

Corporation     Partnership     Sole Proprietorship     Other

Employer Federal ID# \_\_\_\_\_ SIC Code \_\_\_\_\_ Nature of Business \_\_\_\_\_

Subsidiaries and Affiliates Included     Yes     No:    Name: \_\_\_\_\_

**PROVISION AND BENEFIT SELECTION**

Effective Date of Employer Participation: \_\_\_\_\_

**EMPLOYER PAID**

Plan 1 (100/80/50, \$50 deductible)

Plan 2 (80/80/50, \$50 deductible)

Plan 3 (100/50/50, \$100 deductible)

**EMPLOYER VOLUNTARY**

Plan 1 (100/80/50, \$50 deductible)

Plan 2 (80/80/50, \$50 deductible)

Plan 3 (100/50/50, \$100 deductible)

Calendar Year Maximum Options\*:

\$1000     \$1500 (Premium x 1.10)

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\$1000     \$1500 (Premium x 1.10)

Coverage Options\*:

With Orthodontia (See Rate Card)

Take Over Credit (Premium x 1.09)

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With Orthodontia (See Rate Card)

Take Over Credit (Premium x 1.09)

**\* Premiums must be adjusted accordingly**

Class of Employees:

Regular full-time Employees working [    ] or more hours per week.

All Employees

All regular full-time Employees

All Employees, except \_\_\_\_\_

Employees must be actively at work on Effective Date of coverage, if not, coverage will be effective on the First day of the month following return to active employment.

**Participation**

Eligible Employees    \_\_\_\_\_    Enrolled Employees    \_\_\_\_\_

Eligible Dependents    \_\_\_\_\_    Enrolled Dependents    \_\_\_\_\_

Employee Waiting Period:

Waiting Period (Current Employees):     Effective Date     2 Months     Other \_\_\_\_\_

1 Month     3 Months

Waiting Period (New Employees):     1 Month     2 Months

3 Months     Date Employed     Other \_\_\_\_\_

New Employees are covered on the first day of the month following the Waiting Period.

Premiums:

Employee: \$ \_\_\_\_\_    Employee/One Dependent: \$ \_\_\_\_\_    Employee/Family: \$ \_\_\_\_\_    % paid by Employer

Employee \_\_\_\_\_

Dependent \_\_\_\_\_

\_\_\_\_\_  
Participating Employer's Signature    Date

\_\_\_\_\_  
Agent Signature    Date

**Underwritten by: SECURITY LIFE INSURANCE COMPANY OF AMERICA**

APPLICATION FOR GROUP INSURANCE
SECURITY LIFE INSURANCE COMPANY OF AMERICA
Minnetonka, MN

Administered by:
FDI Group
P.O. Box 8023
Novi, MI 48375

GROUP INFORMATION

Group Name
Address
Contact Person
Telephone Fax: Email:
Number of Eligible Employees Number of Enrolled Employees:
Tax ID # Effective Date Requested:

PREMIUMS EMPLOYEE PARTICIPATION

Table with columns: Employer Paid, Employer Voluntary, Employee Paid, Employee Voluntary. Rows: Single, Employee+1, Family.

ELIGIBILITY INFORMATION

To be eligible, an employee must work 30 or more hours per week, and must be actively at work on the effective date of coverage. If not, coverage will be effective on the first day of the month following return to active employment.

Employee Waiting Period:
Waiting Period (Current Employees):
Waiting Period (New Employees):

PREMIUMS

The 1st months' premium is due with initial enrollment. All additional premiums are due on the 1st day of the calendar month of coverage.

Initial Premium Amount due \$ Amount received \$

Additional Information

STATEMENT

It is agreed that the Policy will become effective at rates to be determined by Us,, provided the application is accepted by Us. The Applicant declares that to the best its knowledge and belief that statements and answers are complete and true.

Dated at this day of
Applicant: Agent:
Printed Name: Printed Name:
Title: Tax ID:



**SECURITY LIFE INSURANCE COMPANY OF AMERICA**  
 Minnetonka, Minnesota  
**Group Enrollment Form**

		/ / Mo. Day Yr.	M <input type="checkbox"/> F <input type="checkbox"/>	<b>For Company Use Only</b>		
Social Security No.	Applicant's Name (Last/First/ Initial)	Birth Date	Sex	Effective Date		
		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Plan Code		
Home Address (City/State/Zip)	Telephone No.: ( )	Marital Status		Waiver	CPT	
Name of Employer or Organization (if applicable)		Full-Time Hire Date (if applicable)				
		( )		Group Number	Division Number	
Address (City/State/Zip) (if applicable)		Telephone No:				
ADDITIONAL INFORMATION (if applicable)						
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Family Addition <input type="checkbox"/> New Hire (if applicable) <input type="checkbox"/> Re-hire (if applicable) <input type="checkbox"/> Decline <input type="checkbox"/> Termination-Reason:						
FAMILY INFORMATION List only those eligible family members who are enrolling						
Relationship	Sex M / F	Last Name	First Name	M.I.	Birth Date	Full-Time Student Y / N
<b>COVERAGE SELECTION</b>						
<input type="checkbox"/> Group Dental Coverage provided under the Group Dental Policy issued to the Trusteed Group Policyholder I apply for group dental coverage for: <input type="checkbox"/> Myself only <input type="checkbox"/> Myself and Eligible Dependents 1. Does Spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> Insurer Name:			<input type="checkbox"/> Group Vision Coverage provided under the Group Vision Policy issued to the Group Policyholder (policyholder may be trusteed group policyholder in some states) I apply for group vision coverage for: <input type="checkbox"/> Myself only <input type="checkbox"/> Myself and Eligible Dependents			
I decline coverage for Name _____ Relationship _____ Name _____ Relationship _____ Reason for Declining Coverage _____			I decline coverage for Name _____ Relationship _____ Name _____ Relationship _____ Reason for Declining Coverage _____			
BY MY SIGNATURE BELOW, I HEREBY APPLY FOR THE COVERAGE OR COVERAGES SELECTED ABOVE UNDER POLICY GH-1112(97) ISSUED TO THE EMPLOYERS' VOLUNTARY BENEFIT INSURANCE TRUST			I HEREBY AUTHORIZE PAYROLL DEDUCTIONS FROM MY EARNINGS FOR ANY CONTRIBUTIONS REQUIRED.			
_____ Applicant's Signature Date			_____ Applicant's Signature Date			
Plan Identification:			Administrator:			
_____ _____			Security Life Insurance Company of America c/o Financial Designs Inc 39500 High Pointe Blvd. Ste 400 Novi, MI 48375-5379			

GHA-1164

(Rev 9-05)

**To Be Completed By Employer**  
 Please provide the Effective Date of coverage under your current Employer Sponsored Dental Plan

Employee \_\_\_\_\_ Spouse \_\_\_\_\_ Child 1 \_\_\_\_\_ Child 2 \_\_\_\_\_ Child 3 \_\_\_\_\_