# NexStep

**Group Name_____**

## New Business Checklist

**_____ New Business Submission Form**

*Form #* **Benefit Advantage Plan** ***NBSF (8/06)***

**_____ Master Application**

*two page form –* **Must submit original application with employer signature on 2nd page**

**_____ Single Case Agreement**

**_____** *Copy of the* **Schedule of Benefits (Primary Group Plan)**

**_____ First month's check made payable to:**
**Special Insurance Services**

**_____ Check #**

**_____ Check Amount**

**_____ Agent Appointment Forms** *( if not already appointed)*

**Please mail all New Business Submission materials to:**

Sean Jolley, President
Benefit Partners Group
508 W. 800 N.
Orem, UT 84057
Phone: 888.514.5101
=> Fax: 800.609.7309

## NEXSTEP™ NEW BUSINESS SUBMISSION FORM

**PLEASE FULLY COMPLETE THE ENTIRE FORM, FRONT AND BACK, TO AVOID ANY PROCESSING DELAYS.**

Date: _____ Requested Effective Date: _____

**EMPLOYER INFORMATION:**

Firm Name: _____

Address: _____

_____

Phone #: _____ Fax #: _____ Federal ID #: _____

Nature of Business: _____

Contact Person/Title: _____

Does the firm have employees residing outside the firm's state of domicile? ❑ Yes ❑ No If yes, list states: _____

**GROUP MAJOR MEDICAL INFORMATION:**

Group Major Medical Insurance Carrier: _____

When did current coverage go into effect? _____ What is current waiting period? _____

When does an individual's coverage under the plan become effective?
- ❑ 1st day of month immediately following the end of the waiting period
- ❑ 1st day immediately following the end of the waiting period

Name of employees that have been denied coverage: _____

_____

If an employee rejected coverage, does the employer keep a signed form on record indicating such rejection? ❑ Yes ❑ No

Does employer allow employees who previously declined coverage to enroll:
- ❑ at any time
- ❑ only during designated periods of open enrollment

If enrollment allowed only during periods of open enrollment, when is open enrollment allowed? _____

***Please note, a copy of your current major medical benefit schedule, reflecting the individual in-network deductible and individual in-network out-of-pocket maximum, must be attached to this form.***

**BILLING INFORMATION:**

Mailing/Billing Address: _____

_____

Are multiple billings required? ❑ Yes ❑ No If yes, attach a list of each location and their physical address. (NOTE: Agent must be licensed and appointed in each state.)

How are payroll deductions made?
- ❑ Current (example: June premiums deducted in May)
- ❑ Arrears (example: June premiums deducted in June)

**AGENT INFORMATION:**

Agent of Record: _____

Mailing Address: _____

_____

Phone #: _____ Fax #: _____

E-mail: _____

***A completed and signed Single Case Agreement must be submitted with this form.***

# Employer Application
# NexStep™

*Special Insurance Services, Inc.*
*6509 Windcrest Drive, Suite 200*
*Plano, Texas 75024*
*(972) 788-0699 (800) 767-6811*
*Fax: (972) 960-0377*

**Policy No. MG-100; M-9054E**

Application is hereby made by:

_____
(full name of organization/firm)

Type of Business _____

Located at _____
Number Street

_____
City State Zip

_____
E-Mail Address

*Underwritten by Fidelity Security Life Insurance Company*

**1** Insurance shall be:

Employee Only Cost: _____ % Employer Contribution _____ % Employee Contribution
Dependent Cost: _____ % Employer Contribution _____ % Employee Contribution

**2** Total number of employees: _____
Number of employees eligible for this plan: _____
Number of employees participating: _____
Percentage of participating employees: _____%
Number of dependents to be covered: _____

*Eligible employees (including owners, partners, and executive officers) are defined as those who are engaged in their regular and customary activities (at least 20 hours per week), and not confined at home or in a hospital or medical institution*

**3** In-Hospital Plan of benefits requested for all employees: Plan I: $_____ Plan II: $_____

❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500
❑ $3,000 ❑ $3,500 ❑ $4,000 ❑ $5,000 ❑ Other _____

Outpatient Benefit: ❑ OPI ❑ OPII: Plan I: $_____ Plan II: $_____
❑ $200 ❑ $500 ❑ $1,000 ❑ $2,000 ❑ Other _____

Physician Benefit Plan I: $_____ Plan II: $_____
❑ $15 visit up to the lesser of $120 or 8 visits per family, per Calendar Year
❑ $20 visit up to the lesser of $240 or 12 visits per family, per Calendar Year

Wellness Rider Plan I: $_____ Plan II: $_____
❑ $100 ❑ $200 ❑ $500

**4** Billing Method: ❑ Monthly List Bill (First Month Premium is due at time of application)

Billing Information:
Mailing/Billing Address: _____

Are multiple billings required? ❑ Yes ❑ No If Yes, attach a list of each location and their physical address. (NOTE: Agent must be licensed and appointed in each state.)

Mail Premium Notice to: ❑ Employer ❑ Third Party Payor*

*Third Party Payors must be pre-approved by Home Office. A letter from the employer must be submitted with the business requesting that their billings be sent to the Third Party Payor. The Third Party Payor must also sign a Privacy Non-Disclosure Agreement.

Third Party Payor: _____

Mailing Address: _____

_____

Contact Person/Title: _____

Copy Agent in on all correspondence? ❑ Yes ❑ No If No, all correspondence will be handled directly with the Employer.

The effective date of this insurance applied for will be the later of the first day of the month following the acceptance of employee Enrollment Forms by the Company and receipt of premium payment, or the Employee's effective date under the Employer's Major Medical/ Comprehensive coverage.

Requested effective date for group: _____

I understand that requests submitted to the Company for individual employee cancellation of coverage and return of premium, if any, must be signed by the employee.

Signature of Employer _____ Title _____ Date _____

Contact Person _____ Daytime Telephone No. _____

## EMPLOYER AUTHORIZATION

### DIRECT BILL:

Organization/Firm _____

Billing Address _____ City _____ State _____ Zip Code _____
(If different from the first page)

Employer's Signature _____

### AGENT INFORMATION:

Writing Agent Name _____

Agent Address _____

E-Mail Address _____

Tax ID No. (If none, Social Security No.) _____

Commission Paid To _____

Are you appointed with Fidelity Security Life Insurance Company? ☐ Yes ☐ No
If "No", contact Fidelity Security Life Insurance Company immediately regarding appointment.

Policy No. MG-100; M-9054E

**Application To:**
**Fidelity Security Life Insurance Company**
**3130 Broadway, Kansas City, MO 64111-2406**

**FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE**

# NexStep™

**Arranged by:**
**Special Insurance Services, Inc.**
**6509 Windcrest Drive, Suite 200**
**Plano, TX 75024**

## PLAN INFORMATION:

As selected by the Policyholder

**In Hospital Benefit Amounts**

☐ Plan I:
$ _____ In-Hospital Benefit
$ _____ Optional Out-Patient Benefit: ☐ OPI ☐ OPII
$ _____ Optional Physician Benefit Rider
$ _____ Optional Wellness Rider

☐ Plan II:
$ _____ In-Hospital Benefit
$ _____ Optional Out-Patient Benefit: ☐ OPI ☐ OPII
$ _____ Optional Physician Benefit Rider
$ _____ Optional Wellness Rider

**APPLICANT INFORMATION:**

| | | | | |
|---|---|---|---|---|
| Name (last, first, middle) | | | | Sex ☐ M ☐ F |
| Age | Date of Birth (mm/dd/yy) | Social Security Number | Home Phone # | Work Phone # |
| Street Address | | | E-Mail | |
| City | | State | | Zip Code |
| Employer | | Occupation | | Date of Hire |
| Coverage Selected: | ☐ Employee Only ☐ Employee & Child(ren) | | ☐ Employee & Spouse ☐ Employee & Family | |
| Monthly Premium: | | Requested Effective of Coverage/Change: | | |

**DEPENDENT INFORMATION:**

| | Name (last, first, middle) | Birth Date | Sex | Social Security # |
|---|---|---|---|---|
| Spouse | | | | |
| Child | | | | |
| Child | | | | |
| Child | | | | |

(Use reverse side of form if additional space is needed)

I hereby: ☐ **ENROLL**, or ☐ **CHANGE** as indicated above, for this group insurance coverage for which I am eligible. I authorize my Employer to deduct my contributions, of any, from my salary or wages, and to remit that amount to Fidelity Security Life Insurance Company. I request that this authorization remain in effect until such time as I withdraw it by giving written notice prior to the next premium due date. I understand and acknowledge: that no coverage will take effect for any person to be covered who is not also covered by a Major Medical/Comprehensive Policy including Coinsurance and Deductible, in force at the time of my proposed Effective Date for this coverage; that I am either currently covered under a Major Medical/Comprehensive coverage with this Employer or have enrolled for Major Medical/Comprehensive coverage with this Employer; that the coverage for which I am applying may contain Pre-Existing Limitations; that the Master Policy for this coverage is issued to my Employer; and that I will receive a certificate as evidence of my insurance coverage under the policy.

Applicant's Signature _____ Date _____

Parent or Legal Guardian if the Applicant is under age 18

Agent's Signature (where applicable by law) _____

**DEPENDENT INFORMATION (Continued):**

| | Name (last, first, middle) | Birth Date | Sex | Social Security # |
|---|---|---|---|---|
| Child 4 | | | | |
| Child 5 | | | | |
| Child 6 | | | | |
| Child 7 | | | | |
| Child 8 | | | | |
| Child 9 | | | | |
| Child 10 | | | | |
| Child 11 | | | | |
| Child 12 | | | | |
| Child 13 | | | | |