Colonial Life
Making benefits count.

Producer Contact: 1.800.43VOICE, Option 2, 2
Fax Forms to 1.800.543.8573 or email to newaccountservicecenter@coloniallife.com

Account Information

Account name: _____

Address: _____

City: _____ **State:** _____ **Zip** _____

Phone: (_____) _____ **Fax:** (_____)_____

If this account is associated with another Colonial Life or one of its affiliates' accounts, please provide the name and BCN of the account or master group number:

_____

Account billing address (if different from above address): _____

Contact person for billing and service: _____ _____
First Name Middle Initial Last Name Title

E-mail address: _____

Are there locations that will be written in NY? ☐ **Yes** ☐ **No**

Number of benefit-eligible employees: _____ **Federal Tax ID:** _____

Exact nature of business: _____

Will a third party administer, reconcile and/or remit the premium deductions? ☐ **Yes** ☐ **No**

If yes, is the third party a: ☐ **Payroll Company** ☐ **Professional Employer Organization** ☐ **Other** _____

Please indicate name, address, phone number and contact person _____

_____

***A Premium Services and Administration Agreement may be needed.**

Will any deductions be made pretax? ☐ **Yes** ☐ **No** **If yes, include Flex Plan Supplemental Form.**

Will the employer be contributing any premium toward the Colonial Life benefits? ☐ **Yes** ☐ **No**

Important Compensation Disclosure Information

Colonial Life is committed to helping working Americans and their families minimize personal financial risk with a comprehensive offering of voluntary benefits through the workplace. Colonial Life compensates producers to facilitate the sale and delivery of these valuable benefits. This compensation might include commissions as well as various incentives and awards.

We support the full disclosure of compensation programs for our products, and your insurance advisor can provide you with complete information about these programs. You may also learn additional information about our compensation programs by contacting our Plan Administrator Service Center at 1.800.256.7004.

Is employer/account paying a fee to an insurance advisor for this placement of Colonial Life insurance? ☐ **Yes** ☐ **No** _____
Initials of Authorized Officer

If yes, list advisor(s) names _____

A completed Compensation Consent and Disclosure Form 62291 is required for each insurance advisor receiving a fee.

If fee is paid in the future, it is the employer's responsibility to notify Colonial Life of the change.

The employer account (and/or its assigns) agrees to forward promptly all insurance premiums payroll deducted from its employees to Colonial Life & Accident Insurance Company (hereafter Colonial Life) for payment of employee insurance coverage and to notify Colonial Life promptly of the names of any employees to cease deductions because of termination from employment or otherwise. If the employer fails to notify Colonial Life that an individual's employment has terminated, that an individual has otherwise ceased deductions or where there is some other misunderstanding between the employer and employee concerning the payroll deductions, Colonial Life agrees to reimburse the employer up to one (1) month's premium in the event of loss by the employer as long as a claim has not been paid. Refund of premiums on flexible benefit plan accounts will be made payable to the employer. The issuance of any coverage paid for by payroll deduction pursuant to this agreement does not relieve the employer of the requirements of Workers' Compensation Laws of their state.

Signed at: _____ this _____ day of _____
City and State

_____ _____
Print Name and Title of Authorized Officer Signature of Authorized Officer

Submitted by _____ **Producer #** _____ **Producer Telephone Number** _____

Please check one:

❍ New Account

❍ Existing account implementing a flex plan.
Indicate existing BCN _____

Federal Tax ID# _____

Colonial Life®

Flex Plan Supplemental Form

Plan Dates:

Colonial Life Plan Effective Date: ____/____/____

Initial Enrollment Dates: Start ____/____/____ Stop ____/____/____

Subsequent (Future) Plan Document Date: ____/____/____

Subsequent (Future) Enrollment Dates: Start ____/____/____ Stop ____/____/____

Employer Reminder Notice

We are pleased you have selected Colonial Life & Accident Insurance Company (hereinafter called Colonial Life) as a supplier of insurance under the flexible benefits plan that you are implementing within the guidelines of Section 125 of the Internal Revenue Code. As a supplier of currently acceptable insurance coverage, we would like to remind you of several elements of Code Section 125.

1. You should have a written plan document that addresses the 6 primary elements listed in the Proposed Regulations.
2. You should realize that as a result of salary reduction you, the employer, reduce your FICA (Social Security) contributions as a result of your employees' reducing their FICA contributions. Both of these reductions may ultimately somewhat reduce the Social Security benefit eventually paid to the employee.
3. You should review state statutes as they pertain to state tax implications of employees salary reductions under your plan. In addition, you should check with your Workers' Compensation Insurance carrier to determine if the Workers' Compensation insurance can be based on the reduced gross pay after salary reductions.
4. Because premiums being paid are considered employer paid, certain claim payments will be subject to 1099 reporting by Colonial Life.
5. Payments for the first six months of total disability are subject to FICA tax. Colonial Life will withhold the correct FICA taxes from these claim payments and notify you, the employer, of your obligation to pay the employer's portion of the FICA tax and the amount due. You will be required to add the disability payment to the employee's W-2 or provide a separate W-2 for the amount of the payment.
6. Once employee elections are made, they may not be changed during the plan year except under circumstances outlined in the Plan document. Any changes must be communicated to Colonial Life in writing by your Plan Administrator. Since premiums are considered employer paid, all refunds will be made to the employer. The employer will be responsible for any tax withholdings and reporting and for distributing the refunds to employees.
7. The cost of certain insurance coverage is required to be reported by the employer on the employees' Form W-2 for information only. Colonial Life's hospital confinement indemnity and specified disease products are required to be reported on Form W-2 for this purpose when all or part of the premiums are paid through salary reduction (pretaxed) by the employer. The premiums are not considered to be taxable income to the employee.
8. Certain benefit plans, when pretaxed, may become subject to the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, all employers (other than governmental and church employers) must provide each participant in a welfare or pension benefit plan with a summary plan description.
9. Flexible benefit plans are subject to discrimination rules to ensure highly compensated and key employees are not allowed to benefit from the plan disproportionately compared to other employees. The employer is responsible for complying with the discrimination guidelines.

You should consult your professional advisors, lawyers, and/or Certified Public Accountants for answers to specific questions.

I acknowledge that I have read and understand the Flex Plan Supplemental Form. This also serves as confirmation of existing plan dates, any amendments to them if applicable, and inclusion of Colonial Life products under the plan.

_____ _____

Account Name | Colonial Life Producer Name

_____ _____

Authorized Officer Name | Title

_____ _____

Signature of Authorized Officer | Date (mm/dd/yyyy)

Colonial Life®
Making benefits count.

Colonial Life & Accident Insurance Company
1200 Colonial Life Boulevard
Columbia, SC 29210
803.798.7000
coloniallife.com

Domestic Partner Inquiry

Domestic partner laws vary across the country and such relationships may or may not be recognized in the home state where your account is located.

As a general rule Colonial Life & Accident Insurance Company will recognize domestic partner or civil union relationships from an insurable interest standpoint in those states where such relationships are recognized.

In states where domestic partner or civil union relationships are not recognized, Colonial Life will recognize them from an insurable interest standpoint if such relationships are recognized by the account and domestic or civil partners are allowed to enroll in and be covered by major medical insurance or other core benefits provided by the account.

If applicable to your state and company position, as allowed by law, please signify below if domestic partner or civil union relationships are recognized by your company.

☐ Yes, our company, _____, recognizes domestic partnerships or civil unions* and instructs Colonial Life & Accident Insurance Company to recognize such relationships on any application for insurance submitted from an insurable interest standpoint.

☐ No, our company, _____, does not recognize domestic partnerships or civil unions* and instructs Colonial Life & Accident Insurance Company to not recognize such relationships on any application for insurance submitted. (Note: state law may require your company to recognize domestic or civil union partnerships and if so this form will be considered invalid.)

_____ _____
Plan Administrator signature Date

_____
Billing Control Number (if known) OR Company Address

*Children within domestic or civil union partnerships will qualify as a dependent(s) as long as standard Underwriting and policy language dependent eligibility requirements are met.

Colonial Life Representative: Completed forms should be returned to the Underwriting Department.

Account Summary Sheet

Business Name:_____

Opener:_____

Will there be core enrollment: Yes / No Currently with Aflac or Allstate: Yes / No

New Hire Wait Period: _____ days Deductions: 12 / 24 / 26 / 52 Census: Yes / No

Colonial Life Products to be offered

☐ Accident 1.0
☐ Dental
☐ Cancer Assist
☐ Critical Illness 1.0
☐ Term Life
☐ Whole Life
☐ Universal Life

☐ Disability 1000
OR
☐ Individual Disability
Offer to all employees:
- ☐ First Day Hospital
- ☐ Psychiatric and Psychological Condition

Which two benefit periods:
- ☐ 3 months
- ☐ 6 months
- ☐ 12 months
- ☐ 24 months

Value Add:
- ☐ InfoArmor
- ☐ AD&D
- ☐ Flu Shot

☐ Medical Bridge 3000 OR
Plan:
- ☐ 1 Base Plan
- ☐ 2 Base with Outpatient Surgery
- ☐ 3 Base with Outpatient Surgery, Diagnostic & ER
- ☐ 4 Base with Outpatient Surgery & Doctors' Visits
- ☐ 5 Base with Outpatient Surgery, Diagnostic, ER and Doctor's Visits

Levels: (choose two)
- ☐ 1 $500
- ☐ 2 $1,000
- ☐ 3 $1,500
- ☐ 4 $2,000
- ☐ 5 $2,500
- ☐ 6 $3,000

Option:
- ☐ 1 $1,500 Max T1 $500/T2 $1,000
- ☐ 2 $2,500 Max T1 $750/T2 $1,500
- ☐ 3 $3,000 Max T1 $1,000/T2$3,000

☐ Individual Medical Bridge
Plan:
- ☐ 1 Base Plan HSA Compliant
- ☐ 2 Base with Outpatient Surgery
- ☐ 3 Base with Outpatient Surgery & Diagnostic Procedure

Levels: (choose two)
- ☐ 1 $500
- ☐ 2 $1,000
- ☐ 3 $1,500
- ☐ 4 $2,000
- ☐ 5 $2,500
- ☐ 6 $3,000
- ☐ 7 $4,000
- ☐ 8 $5,000

Option:
- ☐ 1 $1,500 Max T1 $500/T2 $1,000
- ☐ 2 $2,500 Max T1 $750/T2 $1,500
- ☐ 3 $3,000 Max T1 $1,000/T2$3,000

Health Screening:
- ☐ None
- ☐ $50
- ☐ $100

Offer to all employees:
- ☐ Medical Treatment Package

Group Meeting Date:_____

Enrollment Dates & Times:_____

Enrollers:_____

After Welcome Call: BCN:_____ CAN:_____

Rating: _____ CED:_____ PED:_____

Special needs such as Spanish materials, multiple locations, special hours:

_____

Need Assistance? Contact Cheryl Hernandez: 772-285-3348

COMMISSION SET-UP SHEET

COMMISSION ACCOUNT INSTRUCTIONS:

NEW ACCOUNT SET-UP - Complete ALL sections	ACCOUNT MAINTENANCE – Complete sections A, C and D (For all released accounts)
Send completed form to New Account Service Center (NASC) • newaccountservicecenter@coloniallife.com • FAX: 1-800-543-8573 • Mail Stop Code SC140 **NASC will send an e-mail confirmation, which will include the BCN and Commission/Sub Account Number, once the account is set-up prior to the enrollment.**	**Send completed forms to Sales Compensation Service Center:** • salescompensation@coloniallife.com • FAX: 1-888-449-0012 • Mail Stop Code SC433

Maintenance to all roles except the Coordinator Role will require Territory Manager approval.

A. COMPLETE THIS SECTION FOR A NEW COMMISSION ACCOUNT OR CHANGES TO AN EXISTING COMMISSION ACCOUNT:

Account Name: _____

Billing Control Number (existing account): _____ Commission or Sub Account Number: _____

Indicate commission schedule: **CAA** Other: _____

****You can indicate any schedule not listed in the "Other" field.**

B. COMPLETE THIS SECTION FOR A NEW COMMISSION ACCOUNT ONLY:

Enrollment Start Date (mm/dd/yyyy) _____ **Notify the New Account Service Center if enrollment date changes! This date can impact reporting for new account bonuses.**

For a new account, indicate individual(s) who receive new account credit. Case count is for a new account only and will not be changed after account setup.

	Name	Agent Code #	% Split (must total 100%)
Case count			

C. COMPLETE THIS SECTION FOR A NEW COMMISSION ACCOUNT OR CHANGES TO AN EXISTING COMMISSION ACCOUNT:

	Name	Agent Code #
GIF Sales Contact		
GIF Service Contact		

GIF Sales Contact and his/her manager receive all enrollment level information. GIF Service Contact and his/her manager receive information to service the plan administrator. Brokers are not allowed in either field with the exception of a MAP, DMP and Worksite Specialist.

Effective date of change for an existing account (mm/dd/yyyy) _____

Only enter names of individuals here for whom you want to protect the commission assignments and splits. This sheet sets them for the entire enrollment—they are hardcoded and cannot be changed at the Sales Summary level. If no hardcodes are needed, check 'no hardcodes' box.

	Name	Agent Code #	% Split	No Hardcodes
Opener/Maintainer				☐
				☐
				☐
				☐
**Broker				☐
				☐
				☐
Coordinator				☐
				☐
				☐

**** The broker role should only be indicated when using the broker commission schedules.**

D. COMPLETE THIS SECTION FOR A NEW COMMISSION ACCOUNT OR CHANGES TO AN EXISTING COMMISSION ACCOUNT:

Signature of DGA_____ ****Email approval is acceptable**** Date (mm/dd/yyyy):_____

Print DGA Name _____ Agent Code #_____

Signature of TSM/VPS_____ Print TSM/VPS Name _____

Program Request Form

Colonial Life®
1200 Colonial Life Boulevard, Columbia SC 29210

Please complete this form and email it to your region's Program Manager for approval. Forms must be filled out in their entirety to be reviewed. Once the form is reviewed, a Program Manager will reach out to you for next steps.

Program Manager Contacts:

- Northeast: Katie Davis – kadavis@coloniallife.com
- Southeast: Sarah Owens – swowens@coloniallife.com
- Northwest: Trey Fender – tfender@coloniallife.com
- Southwest: Dre Dantzler – aldantzler@coloniallife.com

Please submit forms prior to an enrollment beginning and allow a minimum of TWO business days for review.

Agent Name:	Agent Code Number:
Agent Email Address:	Agent Phone Number:
	TSM/MGA:

Choose the program you'd like to request:
Note: You may only choose ONE program per group!

◯	$5,000 Public Sector AD&D *(New or Existing Group, 10-999 Employees, 50% POPS) (Percentage of People Seen)*
◯	$5,000 Commercial AD&D *(New Group, 10-499 Employees, 50% POPS)*
◯	ERISA *(New Group, 100+ Employees, 75% POPS)*
◯	Flu Shots *(New Group, 50+ Employees, 75% POPS)*
◯	InfoArmor *(New Group, 10-499 Employees, 50% POPS)*
◯	Other (describe)

Group Name:	
New or existing account: ◯ NEW ◯ EXISTING	
BCN (if existing): E	Number of employees:
Will you have 1-1 *(face-to-face)* enrollment sessions? *(No benefit fairs)* ◯ YES ◯ NO	
Has the employer agreed to the POPS *(Percentage of People Seen)* requirement? ◯ YES ◯ NO	
What products are being offered in the group? *(Including core & group products).* *Must offer at least two employee-paid products.*	
Enrollment start date:	Enrollment end date:
AD&D Only: Is this the first year offering AD&D? ◯ YES ◯ NO	If No, when did it last enroll?

ePOP Data Requirements for Web Entry

COMPANY INFORMATION

Company Name: _____

Telephone: _____ Street Address: _____

City: _____ State: _____ Zip: _____

Benefits Contact: _____ Email: _____

Number of Employees: _____ Email Address to send ePOP Document to: _____

State of Legal Construction: _____ Federal Tax ID Number: _____

Is this a Church or Government? Church ☐ Govt. ☐ Legal Entity Type*: _____

*Legally Entity Type: C-Corp, S-Corp, Sole Proprietorship, Partnership, Non-Profit, LLC or Government Entity

Is this an amendment to the original plan? Yes ☐ No ☐

- If yes, what is Original Effective date of the plan? _____
- What is the effective date of the amendment? _____

Current Plan Year Start Date: _____ Current Plan Year End Date: _____

ELIGIBILITY REQUIREMENTS

Waiting Period: _____ Hours per Week: _____ Months per Year: _____

Date of Eligibility: ☐ First of Month following waiting period.

☐ Immediately following the waiting period.

☐ Fifteenth of month following waiting period.

Are union employees eligible? Yes ☐ No ☐

Are seasonal employees eligible? Yes ☐ No ☐

- If yes, what is the maximum number of consecutive work weeks an employee must work to be classified as seasonal? _____

CORE BENEFITS

Core Benefits being offered on a pre-tax basis (*check all that apply*):

Health ☐ HSA ☐ Vision ☐ Dental ☐ Group Term Life ☐ Disability ☐

Cancer ☐ Accident ☐ Bridge/Gap ☐ Hospital Confinement ☐

Other ☐ : _____

OPTIONAL HSA AMENDMENT LANGUAGE

Health Savings Account contribution ☐

HSA Amendment effective date: _____

ePOP Data Requirements for Web Entry –PAGE 2

OPTIONAL ENROLLMENT TYPE LANGUAGE

(*Check all that apply.*)

☐ Negative/Default Enrollment (*Employees are automatically enrolled in the pre-tax plan when first eligible.*)

☐ Evergreen/Rolling Enrollment (*Employee elections roll over from year-to-year.*)

AFFILIATES

(*Please list all other associated companies covered by this POP Plan.*)

Affiliated Employer Name #1: _____

Affiliated Employer Name #2: _____

Affiliated Employer Name #3: _____

Signature **Date**

Submit to: Ameriflex Client Services

Email: epop@myameriflex.com **Fax:** 800.282.9818 **Mail:** 7 Carnegie Plaza Ste. 200, Cherry Hill, NJ 08003