BeneBridge™ Setup Form

I. EMPLOYER INFORMATION

Employer Name: ______________________________

EIN: ______________ **SIC#:** ______________ **Business Industry:** ______________________

Street Address: ______________________________

City: ______________________ **State:** __________ **Zip:** ______________

Primary Contact: ______________________ **Title:** ______________________

Phone: ______________________ **Email:** ______________________

Secondary Contact: ______________________ **Title:** ______________________

Phone: ______________________ **Email:** ______________________

Employer Type: ○ School System ○ Government ○ Commercial ○ Other: ______________

Number of Eligible Employees: ______________

II. BILLING INFORMATION

Insurance Deduction Mode: ○ Monthly (12) ○Semi-Monthly (24) ○ Bi-Weekly (26) ○ Other______________

BBA Billing Frequency: ○ Monthly (12) ○Semi-Monthly (24) ○ Bi-Weekly (26) ○ Other______________

Employer Invoice Contact: ______________________ **Phone:** ______________________

Email: ______________________________

Street Address: ______________________________ **Bldg/Suite #** __________

City: ______________________ **State:** __________ **Zip:** ______________

Desired Method of Invoicing:

○ E-invoice (Balance Bridge)

○ Paper Invoice; **Invoice Format - Sorted By:** ○ Product ○ Employee ○ Location

○ Deduction Register; please attach sample file layout with this form.

Please direct any billing questions to billing@bbadmin.com or by phone at (800) 845-7519

III. SERVICING AGENT INFORMATION

Agent Name: ______________________ **Agency Name:** ______________________

Phone: ______________________ **Fax:** ______________________

Email: ______________________

Commission Split Information: **(if known)** ______________________

IV. PLAN/PRODUCT INFORMATION

Plan Year Begins: ______________________ **Plan Year Ends:** ______________________

Mail Policies To: ○ Agent ○ Group ○ Employee

Which of the following will be offered to employees?

Pre-Tax/Post-Tax *Check Both for Employee Choice*

○ ○ Humana Cancer
○ ○ Humana Accident
○ ○ Humana Critical Illness
○ ○ Humana Heart/Stroke
○ ○ Humana Hospital Indemnity
○ ○ Humana Dental
○ ○ Humana Vision
○ ○ Leaders Life VGTL
○ ○ Leaders Life Term to 100
○ ○ Leaders Life Wage Protector
○ ○ Ameritas Dental
○ ○ Ameritas Vision
○ ○ 4 Ever Group Life
○ ○ NGL Disability
○ ○ *Health; If including, who is the carrier? ______________________
○ ○ SafetyNets Supplemental Benefits

Do you intend to offer an employer contribution for any of the listed products? If so, please describe:

____
____
____
____
____

*Please list any and all products you would like to offer but are not listed to the left:

____
____
____
____
____

Please attach sales brochures and rate sheets for all products that are being offered.

***Please fill out the requested information on the BeneBridge Carrier Setup Form (page 4) for the health plan along with any products you entered in the box above.**

V. ENROLLMENT INFORMATION

Will enrollers be paid a commission on each policy written? ○ Yes ○ No

Open Enrollment Period: ______________________________ through ____________________________________

Enrollment Style: ○ **Every Employee -** every employee must complete either an Enrollment Form or Waiver

○ **Changes Only** - employer continues premium deductions unless employee indicates desire to change.

What service(s) will BBA be providing: ☐ Sec. 125 Administration ☐ 403(b) Administration ☐ COBRA Administration

BeneBridge has the ability to import current census and benefit information prior to enrollment. File layout requirements can be found at http://bbadmin.com/forms/employer/BBA_Standard_File_Layout.pdf

If any, which of the following data types do you intend to submit? ☐ Employee Census ☐ Deduction/Benefit Data ☐ Employee Dependent Census

Please fill in the requested information for anyone working with this group as a benefits administrator or enroller:

First and Last Name	Benefits Administrator	Enroller
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

BeneBridge™ Carrier Setup Form

Please fill out the requested information below for your group's health plan along with any product you would like to offer your employees that is not listed on page 2 of this form.

Additionally, please provide supporting documentation including a sample application, rates, and sales brochures for any product you list here. We will do our best to honor every request made in this section. (Please be aware that our ability to interface with these carriers is dependent upon the carriers requirements.)

Product/Carrier: ______________________ **Contact Name:** ______________________

Email: ______________________ **Phone:** ______________________

Yes No

○ ○ **Will BBA need to provide the carrier with eligibility data?** If yes, please provide instructions.

○ ○ **Will the employer be contributing any money towards the employee's premium for this product?** If yes, please provide detailed explanation: ______________________

____

○ ○ **Will BBA be collecting premiums for this product?** If yes, please provide the remittance address below:

Street Address: ______________________ **Bldg/Suite #:** __________

City: ______________________ **State:** __________ **Zip:** __________

Product/Carrier: ______________________ **Contact Name:** ______________________

Email: ______________________ **Phone:** ______________________

Yes No

○ ○ **Will BBA need to provide the carrier with eligibility data?** If yes, please provide instructions.

○ ○ **Will the employer be contributing any money towards the employee's premium for this product?** If yes, please provide detailed explanation: ______________________

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Street Address: ______________________ **Bldg/Suite #:** __________

City: ______________________ **State:** __________ **Zip:** __________

Product/Carrier: ______________________ **Contact Name:** ______________________

Email: ______________________ **Phone:** ______________________

Yes No

○ ○ **Will BBA need to provide the carrier with eligibility data?** If yes, please provide instructions.

○ ○ **Will the employer be contributing any money towards the employee's premium for this product?** If yes, please provide detailed explanation: ______________________

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Street Address: ______________________ **Bldg/Suite #:** __________

City: ______________________ **State:** __________ **Zip:** __________

Product/Carrier: ______________________ **Contact Name:** ______________________

Email: ______________________ **Phone:** ______________________

Yes No

○ ○ **Will BBA need to provide the carrier with eligibility data?** If yes, please provide instructions.

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Yes No

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