

New Case Set-up Form

Group Effective Date:

Enrollment Begin Date:

☐ New Group

Group Number:

Enrollment End Date:

☐ Renewal of Existing Group

Employer/Group Information

Employer/Group Name:		Phone Number:
If "Other" give details:		
Employer/Group Address:		
City:	State:	Zip:
Tax ID Number:		
Email Address:		
Part of Section 125 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," will all employers participate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan Month:
Plan Administrator:	Employer Paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Employer Paid:

Underwriting Information

Nature of Business:	SIC:
Number of Eligible Employees:	Minimum Hours Worked:
List all states where applications are to be written (If Individual):	
Situs State (If Group):	
Benefit of Waiting Period:	
Products to be Written: <input type="checkbox"/> Safeguard Term Life - Individual <input type="checkbox"/> Safeguard Term Life - Group <input type="checkbox"/> Better Living Benefit (Optional Rider) <input type="checkbox"/> Waiver of Premium (Optional Rider)	
If "Group," will the Employer be contributing to the premium? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," what percentage?
Is this a take-over of existing business? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please specify the current carrier and product type:

Billing Information

Should billing information be verified with the agent prior to contacting the employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Billing Contact Person and Title:		Phone:
Billing Address (If different from above):		
City:	State:	Zip:
Is this a third-party administrator? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this a multi-location employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," how many and which states?	
Will all bills be coordinated through one office? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No," please provide details of billing locations below:	



Employer/Group Name:

Billing and Administration Information

Premium Billing Order (Please choose one): ☐ Alpha ☐ Employee Number ☐ Policy Number

Billing Frequency (How often a bill is sent): ☐ Monthly ☐ 13th-ly ☐ 10th-ly ☐ 9th-ly ☐ Other Explain:

Payroll Frequency (How often paid): ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other Explain:

For "Bi-weekly" frequencies, will deductions be take out of: ☐ 24 Paychecks ☐ 26 Paychecks

Billing Method (please choose one): ☐ List Bill ☐ Self Bill*

**Requires explicit payment detail from the employer/group, i.e., employer status (terminations, leave of absence, etc.). Deduction amounts must be broke down into individual amounts for plans and dependents. This information must accompany every premium payment.*

First Payroll Deduction Date:	First Bill Date:	Requested Effective Date:
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Note: Policy issue dates will always be the first of the month and cannot be prior to signature dates.

Billings are mailed 10 days prior to the premium due date. If billing should be mailed at a different date, please indicate the date below.

Agent and Enroller Information

Mail Policies to: ☐ Insured ☐ Agent ☐ Employer

Note: Policies must be delivered in the states in which the applications were signed.

Will this case be enrolled by agents or enrollment firm? ☐ Agents ☐ Other

Servicing Agent Name:	Agent Number:	
Servicing Agency Name:	Market Code:	
MGA Name:	Email:	Phone:

Address:

City:	State:	Zip:
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Agents or enrollers conduting enrollment
(Use separate sheet of paper if needed for additional names of agents or enrollers)

Name	Agent Number	Heaped or Level	Commission Split %	Product Split %

Are agents/enrollers listed above licensed, appointed, contracted with AFR Life in all states where enrollments will take place? ☐ Yes ☐ No

Explain any "No" answer: