



**List Bill New Business Transmittal
- Contingent Issue-**

List Bill Plan: New Plan or Addition to Plan

List Bill Type: Standard List Bill or _____

_____ Date

List Bill Number (GBN): _____ Affiliation Code: _____

Name of Company _____ Company Phone # _____

Billing Address _____

City _____ State _____ Zip _____

Payroll Contact _____ Phone Number (Extension) _____ Email Address _____

Agent Name _____ Agent # _____ Agent Phone Number _____ Agent Email Address _____

Initial Premium Check Enclosed Bill Account Billing Frequency: Monthly Other
*Mode of payment other than monthly requires prior Home Office Approval

New employees are eligible for benefits in: 30 days 60 days 90 days days

Requested Effective Date _____ Date of 1st Payroll Deduction _____ Number of Eligible Employees _____

Send Policies to: Agent Employer Employee List Bill/Application Fee \$ _____

Indicate the type of policy being applied for within this enrollment. List all applicants below or attach equivalent census:

Name of Applicant Last, First MI (Please Print)	Employment Date For New Employee Additions	Plan Type	Last 4 Digits of Employee's SS#	Monthly Deduction Amount	If employee did not elect to participate in the health insurance program please explain:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees listed above have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

SIGNATURE OF ADMINISTRATOR

DATE