

Worksite Advantage

Section 125

Required Forms Packet

Agent _____

AO Number _____ **Agency Number** _____

Agency Owner _____

Company _____

Attach all forms and employee list to the Worksite Account in EPIC.
Tag (@WorksiteApproval) for all communication concerning the Worksite Account.
Tag (@FranchiseActivity) when attaching an updated employee list.

EMPLOYEE ENGAGEMENT PROCESS

The most important part of a successful benefit enrollment is 100% participation by all employees. This benefits you in three ways. (Please initial)

___ **1. Tax Savings:** The more employees that participate in the plan by purchasing pre-tax products, the greater your tax savings as an employer. This works by reducing the amount of taxable payroll on which you pay Federal Insurance Contribution Act (FICA) tax and Federal Unemployment Tax Act (FUTA).

___ **2. Employee Goodwill:** As discussed, we will provide an Accidental Death Policy to all eligible employees with no cost to them for the first policy year. We will also provide a Health Savings Discount card to all eligible employees at no cost. We will make sure your employees know that these benefits are being made available on your behalf.

___ **3. Compliance:** Our goal is to make sure your plan stays in compliance with Section 125 guidelines. Your plan stays in compliance when you ensure that all employees have an opportunity to participate in the benefits.

Enrollment Date(s): _____

Enrollment Start Time: _____

Contact Person Day of Enrollment: _____

Person Who Will Receive Deduction Authorizations: _____

Enrollment Location: _____

___ Employee List With Names And Hire Dates

___ Employer Verification Call

Location Checklist

___ Private location to discuss HIPAA sensitive health questions

___ Easily accessible to all employees

___ Table, chairs, power outlet, etc.

COMPANY INFORMATION

Name of Company	Account #	() - Phone Number	() - Fax Number	Total #	Eligible Employees
Company Billing Address	City	State	ZIP		
Company Physical Address (if different from billing address)	City	State	ZIP		
Employer/Owner/Decision-Maker	() - Phone Number	Email Address			
Company Billing/Payroll Contact (Person who handles deductions)	() - Phone Number	Email Address			
Does Company use <input type="checkbox"/> payroll company or <input type="checkbox"/> accountant?					
Payroll Company or Accountant (if applicable)	() - Phone Number	Email Address			

BILLING INFORMATION

1. Premiums are deducted: (check one)
 weekly (52)
 bi-weekly
 semi-monthly
 monthly

2. Payments will be sent: (check one)
 weekly (52)
 bi-weekly (26)
 semi-monthly (24)
 monthly (12 bills)
 monthly (12 bills -4/4/5)
Circle Payroll Deduction Day of the week
M T W TH F SA SU
 monthly (12 bills -2/2/3)
Fill in the Employer's 1st payroll deduction of the calendar year
 mm dd yyyy
 semi-monthly (20 bills) gov/schools
 9 monthly (9 bills) gov/schools
 10 monthly (10 bills) gov/schools
 every 4 weeks (13 billings per year)
Requires senior management approval

3. Request Online Billing **Yes** **No**
4. Type of Business (Give Details) _____
5. Date Company was established mm / yyyy (Must be at least 1 year old)
6. Enrollment Period From mm / dd Through mm / dd
 First Deduction Date mm / dd / yyyy Policy Effective Date mm / dd / yyyy
7. Employees should be listed on billing in what order? (check one)
 Alpha
 SS#
 EE#
8. Are any of the employees leased? **Yes** **No**

SECTION 125 SPECIAL INFORMATION

1. Are existing Payroll Deduction policy premiums being redirected to allow pre-tax salary reductions? **Yes** **No**
 If "yes," premiums must be shown on the employee's election forms and employees listed on the New Business form.
2. Section 125 policies should be billed:
 on the same billing as other policies
 on a separate billing

AO #: _____ Agent Number: _____ Agency Number: _____

Liberty National Life Insurance Company
Section 125 Premium Only Plan

PLAN ADOPTION AGREEMENT

Instructions to Employer:

You must complete, sign, and date this Plan Adoption Agreement in order to adopt the Liberty National Life Insurance Company Premium Only Plan. The Plan, once adopted, will become effective as of the date you specify below in item #3. Do not specify an effective date earlier than the first day of the payroll period beginning after the day on which you sign the Plan Adoption Agreement.

1. Employer's full name: _____

2. List any affiliated employers or other office locations, if any, who will participate in the Plan Enrollment:

A.	_____	_____	_____	_____	_____
	Employer	Address	City	State	Zip
B.	_____	_____	_____	_____	_____
	Employer	Address	City	State	Zip
C.	_____	_____	_____	_____	_____
	Employer	Address	City	State	Zip
D.	_____	_____	_____	_____	_____
	Employer	Address	City	State	Zip

3. Effective Date: _____ (mm/dd/yyyy)

4. Plan Year:

- The twelve month period commencing on _____ (mm/dd) and ending on _____ (mm/dd).
- The first Plan Year shall be a short Plan Year beginning on _____ (mm/dd/yyyy) and ending on _____ (mm/dd/yyyy).

5. Franchise number: _____

6. Employees shall be considered to work full-time if they work at least _____ hours per week
[specify minimum number of hours].

7. Liberty National Life Insurance Company Qualified Benefit Plans shall mean:

- | | |
|--|--|
| <input type="checkbox"/> Liberty National Division Cancer Insurance | <input type="checkbox"/> Liberty National Division Hospital Intensive Care Insurance |
| <input type="checkbox"/> Liberty National Division Group Term for Life Insurance | <input type="checkbox"/> Liberty National Division Accident Protector Max Insurance |
| <input type="checkbox"/> Liberty National Division Dental Alternative | <input type="checkbox"/> Liberty National Division Accident Plan Insurance (ACB) |
| <input type="checkbox"/> Liberty National Division Vision Plan | |

8. Employer's Qualified Benefits to be included in the Plan are:

- | | |
|--|---|
| <input type="checkbox"/> Employer's Group Term Life Plan | <input type="checkbox"/> Employer's Group Health Plan |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

PAYROLL DEDUCTION AGREEMENT
BETWEEN
LIBERTY NATIONAL LIFE INSURANCE COMPANY
AND

COMPLETE NAME OF EMPLOYER (FIRM)

For the benefit and convenience of its employees, _____,
(hereinafter referred to as the "Employer") agrees to provide for payroll deduction for insurance by Liberty National Life Insurance Company, McKinney, Texas (hereinafter referred to as "Liberty National Life").

Each employee will authorize payroll deduction in a manner agreeable to the Employer and Liberty National Life. An employee may stop payroll deduction by providing appropriate notice to the Employer and Liberty National Life.

Deductions on a schedule to be agreed upon by Liberty National Life and the Employer will be made from salary paid to employees and such deductions will be paid promptly by the Employer to Liberty National Life.

The Employer assumes no responsibility for payroll deduction after the termination of employment of an insured employee, or after an employee stops payroll deduction by providing appropriate notice.

The Employer agrees to continue deductions and remit all premiums as long as the employee agrees to pay for their coverage. Either the Employer or Liberty National Life may terminate this Agreement as of any date by giving at least 30 days written notice to the other prior to such date. After termination of this Agreement, the payment of premiums shall be entirely and directly between each employee and Liberty National Life.

Signature of Employer:

AO #: _____

Date: _____

Agency: _____

By: _____

Agent Name: _____

Title: _____

Signature of Agent:

Signatures of Affiliated Employers:

By: _____

Signature of Agency Director:

Title: _____

By: _____

Signature of Agency Owner:

Title: _____

LIBERTY NATIONAL LIFE INSURANCE COMPANY APPLICATION FOR GROUP TERM LIFE

Administrative Office:
P.O. Box 8080
McKinney, Texas 75070

1. a. **Group Policy Number:** LNGE0

b. **Holder:** _____

2. **Group Effective Date:** Date of first premium deduction

3. **Eligible Person:** Current employees, retired employees, former employees and directors of
the Holder, and their dependents

Authorized Signature for the Policy Holder

Date

Agent Signature

AO#

Agency
(Not required for
5 digit AOs)

The signing of this application by the Policy Holder (employer) does not constitute an endorsement of Liberty National Life Insurance Company or the Group Term Life Insurance product.

Typed employee list with hire dates must be signed by the employer/payroll administrator. List only those employees who work 28 or more hours per week.

XYZ BUSINESS

1234 STREET AVE, SUITE 321
DALLAS, TX 75000
p: 123.555.1234 f: 123.555.2345
www.xyzbusiness.com

Below is a complete list of XYZ Business employees and their hire dates:

Adams, Chris	February 12, 1992
Douglas, Marsha	September 2, 2000
Dugan, Janelle	March 17, 2002
Evans, Dan	August 28, 1999
Frank, Jim	January 15, 1997
Gregory, Nancy	March 22, 2000
Hudson, Mary	November 5, 2006
Jackson, Sam	October 2, 2003
Jones, Mark	July 21, 2001
Lawton, Judy	April 3, 2009
Michaels, Eric	December 11, 2004
Peterson, Tom	March 21, 2009
Smith, Jay	June 10, 2005
Wilson, Wendy	May 4, 2007

Jane Smith

Employer/Payroll Administrator Signature

SAMPLE