



This form must be signed by an authorized representative of the Employer/Organization named below. It is not an application for insurance. **Please print.**

EMPLOYER INFORMATION:

Name of Company (Employer) or Organization

Type of Business

Company Phone Number

Send Billing Statement to: Company Administrator

Outside Administrator

Company Administrator Payroll Contact or Outside Administrator

Email Address

Billing Address – Line 1

Line 2

Line 3

City

State

Zip

Fax Number

Number of Eligible Employees

Projected Number of Enrollees

Requested Effective Date

*Date of First Payroll Deduction

Start Date for Enrollment

*If deductions are made through payroll, allow 6 weeks from the end of the enrollment period in setting the effective date. This will allow the payroll administrator time to complete the deductions.

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

Payroll Frequency: *Weekly (52) *Bi-weekly (26) Semi-monthly (24) Monthly (12)

*Premium Holidays must be used.

Billing Frequency: Monthly *Other

List Bill/Application Fee: \$ _____

*Payment mode other than monthly requires prior Home Office approval.

Employer Contribution: Yes No

If Yes-Amount (percentage or dollar): _____

AGENT INFORMATION:

Agent Name	Agent Number	Agent Phone Number	Agent Email Address	Percent
1.				
2.				
3.				
4.				

EMPLOYER'S ATTESTATION OF EACH EMPLOYEE'S WORK STATUS

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees to be enrolled in this program 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 EMPLOYER / ADMINISTRATOR

DATE

PRODUCTS, UNDERWRITING CLASS AND UNIFORMITY OF PURCHASE

Select Individual Products and Underwriting Method

Requested Underwriting	SI	GI	TI
Hospital Indemnity			
GAP			
Accident			
Short-Term Medical			
Critical Illness			
Dental			
Whole Life Only			
WL/TL Blend 75/25			

SI – Simplified Issue GI - Guaranteed Issue TI – Telephone Interview

Life Products- Uniformity of Purchase Method

Purchase Method	
Fixed Face Amount	
Fixed Percentage of Benefit Bank	
Fixed Premium Purchase	

ACCEPTANCE OF LIST BILL PROGRAM

We, the employer, wish to participate in Philadelphia American Life Insurance Company's (PALIC) List Bill Program. Our Payroll Department is prepared to: 1) honor the requests signed by our employees for benefits offered by PALIC, and 2) forward to PALIC the payroll-deducted premiums as stated on the list bill statement.

We understand that we or PALIC may, upon reasonable notice to the affected party, terminate this List Bill Program. In that case, the payment of premium will be a matter of accounting directly between the employee and PALIC. In addition, any employee may voluntarily discontinue their payroll deduction for this insurance. Written notice should be forwarded to PALIC. We also agree to honor all payroll deduction changes resulting from premium increases due to age changes, rate increase and dependent eligibility when presented.

We acknowledge that PALIC assumes no responsibility for compliance with the Employee Retirement Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirement contained therein. PALIC is not acting as a sponsor as defined in ERISA.

Please check the appropriate box:

- We hereby certify that the premium for the insurance coverage is paid by the company or that the company is making a contribution towards each employee's insurance premium.
- We hereby certify that the premium for the insurance coverage is being payroll deducted from each applicant's earning only as a convenience to the employee and that our only function will be to remit the premium payment to PALIC within the required 31 day grace period provided by the policy(ies).

Please indicate below whether a list of applicants will be provided by completing the attached List Bill New Business Transmittal form or by attaching an equivalent employee census.

- All applicants to be enrolled are listed in the attached PALIC's List Bill New Business Transmittal form.
- Attached is employee census data of all applicants to be considered for enrollment.

SIGNATURE OF EMPLOYER / ADMINISTRATOR

DATE