New Case Submission Checklist
Dearborn National Short Term DI

To ensure that your applications are processed as quickly as possible, just follow this checklist

1	The employer completes and signs the Membership Application	☐
2	The employer completes and signs the Employer Application	☐
3	The employer must provide a copy of the following information: **If a sole Proprietorship** • 1040 Schedule C • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (if filed) **If a Corporation** • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (most recent) **If a Partnership** • Wage Detail Report from DUA QUEST System/WR-1 Mass. Quarterly Payroll (most recent) New Business – If tax information is not available, the owner must provide copies of a DBA Certificate, Business License, Articles of Incorporation or other proof deemed appropriate by Dearborn National.	☐
4	Each eligible employee completes the Employee Application	☐
5	Each employee signs a Payroll Deduction Form (rate sheet)	☐
6	Pay your **first premium**: • Pay over the phone: (781) 228-2222. Payment Confirmation #:_____ -or- • Complete Electronic Payment Request Form -or- • Enclose check payable to Health Services Administrators (HSA) *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*	☐
7	Enclose Annual Membership Fee of $25 (Payable to HSA) or pay online (see #6 instructions above) -or- If enrolling through an Association or Chamber of Commerce, please indicate: Name of Association or Chamber: _____ If not already a member of a participating Association or Chamber of Commerce, additional requirements may apply such as completing a membership application and paying dues.	☐
8	Send all required documents (including this checklist) to: **Corporate Office** 135 Wood Road Braintree, MA 02184 -or- **Regional Office** 574 Boston Road Billerica, MA 01821 Sales Rep: Contact Info:	

PLEASE NOTE: Complete applications and premium payment for new business must be **received by HSA at least 5 business days prior to the requested effective date.**

All coverage will be effective on the 1st day of the month. Once your enrollment has been approved and processed, you will receive a member confirmation by mail with your account number. Your permanent ID cards will be issued to you directly by the carrier. **Permanent ID cards generally take 7-10 business days from date your enrollment was approved and processed.**

Health Services Administrators
Insurance Benefits Made Easy

GUARANTEED ACCEPTANCE

DISABILITY INCOME PLAN

HSA is pleased to make available to its members and employees a unique disability income plan which can provide an easy solution **to protect your most valuable asset……your ability to earn a living!**

Do you have a need for disability insurance? If you can't afford to be disabled and be without income for one, two, three or even up to twelve months, the answer may be YES.

Look at These Highlights

- **Guaranteed acceptance** - no health statements to complete*****
- Benefits will begin on the **15th calendar day** of disability due to a **non-occupational** accident or sickness
- Choice of benefit duration **(26 or 52 weeks)**
- Choice of **weekly benefit** amounts (up to **$1150 per week**)
- **Voluntary enrollment**, no participation requirements (employees decide if they want to participate and can pay for their own coverage) and no employer contribution required
- Available to all employees who work at least 20 hours/week
- Low premiums - due to **HSA's** group buying power

*****Acceptance is guaranteed, however, pre-existing conditions do apply. Benefits will not be paid during the first 12 months on the plan for any conditions for which treatment was received in the 12 months prior to your effective date.

Health Services Administrators
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hsainsurance.com

Membership Application

Please complete each section of this application. Failure to do so could delay enrollment.

Employer information

Employer name_____ Date business established (Mo./Yr.) _____/_____

Employer address _____

City _____State _____ Zip _____

Owner/principal contact name (first and last) _____ Title_____

Business Phone _____ Cell phone _____ Fax _____

Email _____ Website _____

Billing address _____

City_____State _____ Zip _____

Type of business ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ LLC ❑ Other: _____

Nature of business: _____

Employer tax ID# _____ SIC code_____

Do you regularly employ at least one individual that is not an owner and/or the spouse of an owner? ❑Yes ❑ No

Number of full-time employees (30 hours or more per week; including owner) _____

Number of part-time employees (less than 30 hours per week) _____

Quote # (from Group Proposal) _____

Certification

1. The company named above is a bona fide business and not in operation for the sole purpose of obtaining health insurance.
2. All enrollees are actively working for financial compensation and are covered by Worker's Compensation as required by law.
3. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
4. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
5. Payments not received by the 10th of the month are subject to a late fee, currently $25.
6. Payments not received by the 20th of the month are subject to a pending termination fee, currently $50.
7. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier.
8. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $20.
9. Member firms must maintain good standing in their respective Business Association or Chamber of Commerce to participate in the group insurance programs offered through HSA.
10. HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.

I certify that the information on this form is true and complete, that I understand and agree to the above administrative requirements, and that I have the legal authority to sign on the company's behalf.

Signature _____ Title _____ Date _____

Broker name (if applicable) _____
Address _____
City _____ State _____ ZIP _____

For office use only
Account representative _____

Corporate Office: 135 Wood Rd, Braintree, MA 02184 | (781) 848-4950 | (877) 777-4414 | (781) 848-7020 fax

Dearborn National

2012 V1

EMPLOYER APPLICATION
GROUP VOLUNTARY SHORT TERM DISABILITY

EMPLOYER INFORMATON

Employer *(Correct Legal Name)* ☐ **Sole Proprietor** ☐ **Corporation** ☐ **Partnership** ☐ **Other**_____			
Mailing Address Street City State Zip *(DO NOT USE P.O. BOX)*			
Telephone Number	Nature of Business	Waiting period (Future employees) *Select one*_____30 Days _____60 Days	
Requested Effective Date *(must be 1st of the month)*	Benefits Payable *(15th day accident, 15th day sickness)* Benefit Duration *(Select one)* ☐ 26 Weeks ☐ 52 Weeks	No. of Eligible Employees	No. enrolled

The undersigned employer is applying for group coverage through Health Services Administrators ("HSA"). Application for membership includes group insurance provided under the master group policy(ies) issued by Dearborn National Life Insurance Company (the "Company") to HSA.

1) Each participating employer shall subscribe to and adopt the terms and provisions of HSA.
2) Each participating employer shall be bound by the provisions, conditions and limitations of the Master Group Policy, the General Conditions in the Application for Voluntary Benefits, and any applicable administrative provisions.
3) Insurance issued hereunder is in consideration of the Application of the Participating Employer and the payment of premiums when due.

Any Employer shall cease to be a participating employer under HSA on the earliest of the following dates:

1) the date the employer no longer meets one or more of the requirements set forth in this application for membership;
2) the date he discontinues or suspends active business operations or is placed in bankruptcy or receivership;
3) the date his business loses its entity by means of dissolution, merger or otherwise; or
4) the date the Master Group Policy is terminated.

It is understood and agreed by the undersigned that HSA is not an insurer, nor does it have any obligation under any policy of insurance. All claims for and benefits provided by the insurance applied for shall be made to and payable by the Company in accordance with the provisions of such policy(ies). The Trust Agreement and Master Group Policy(ies) held by HSA are available for inspection during regular business hours at the office of the Company.

GENERAL CONDITIONS

1. All active employees who work at least 20 hours a week are eligible to enroll.
2. Each employee must make written application to Dearborn National Life Insurance Co. and must be actively at work on his effective date for coverage to become effective. If not actively at work (as defined in the policy) on the day coverage would otherwise become effective, an employee's coverage will begin on the date of his return to Active Work.
3. Premiums are due and payable monthly on the first day of each month.
4. No insurance under this Application will become effective until this Application is accepted and approved by Dearborn National Life Insurance Company.
5. I have read and understand all the sections of this application.

The above information is accurate to the best of my knowledge. I understand that the information on this Application and any other information I provide shall serve as the basis for the insurance to be issued, and that I have a duty to notify the Company of any changes. I have relied upon no oral or written representations that contradict item (2) above.

Date Signed _____ **Authorized Signature/Employer**_____

PREMIUM CALCULATION

Employee Name	Age	Weekly Benefit	Benefit Plan 26 or 52 week	Monthly Premium $
		TOTAL MONTHLY PREMIUM		

FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

☐ New Enrollment ☐ Change **Enrollment Form**

Administrative Offices: Downers Grove, Illinois I Cleveland, Ohio I Dallas, Texas

EMPLOYER: If group is self-administered, submit enrollment form ***only*** if evidence of insurability is required. If group is not self administered, submit enrollment form to us.

EMPLOYEE NAME — LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	DATE OF BIRTH	DATE OF HIRE (FULL TIME)

SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)	EARNINGS $ ☐ Weekly ☐ Monthly ☐ Annual	JOB TITLE	CLASS

EMPLOYER	GROUP NO./ACCOUNT NO. /	LOCATION

COVERAGE SELECTION: **Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

BASIC COVERAGE(S)				**Supplemental Life**	**Supplemental AD&D**	**Other** _____
Basic Life/AD&D	**STD Benefit**	**LTD Benefit**	**Dependent Life**	☐ Add ☐ Change ☐ Del.	☐ Add ☐ Change ☐ Del.	☐ Yes ☐ No
☐ YES ☐ NO	☒ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	$ _____	$ _____	$ _____

VOLUNTARY COVERAGE(S)	**(A)dd (C)hange (D)elete**	**Total Amount of Coverage Applied for**	**If (C), my prior coverage was**
Voluntary Short-Term Disability ☐ YES ☐ NO			

*** Review the following guidelines which apply to voluntary coverage(s)**

- You may enroll, apply for additional coverage, or request a change to current voluntary benefits only during a scheduled enrollment period.
- Your weekly STD benefit may not exceed 70% of your basic weekly earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- If you are eligible for state-mandated temporary disability benefits, or any employer sponsored income replacement benefits, the combination of your state mandated benefit or other income benefit and your STD weekly benefit may not exceed 70% of your basic weekly earnings.
- New Voluntary STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA).
- If your earnings are based in whole or in part on commissions, commissions will be averaged over the 12-month period prior to the date disability begins.

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK AS DEFINED IN THE POLICY ON THE DATE MY COVERAGE WOULD OTHERWISE BECOME EFFECTIVE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I MEET THE POLICY DEFINITION OF ACTIVELY AT WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in OR or VA.)

FOR FDL USE ONLY

EMPLOYEE SIGNATURE _____ DATE ____/____/____

EMPLOYEE HOME ADDRESS	**EFFECTIVE DATE**

Health Services Administrators
Insurance Benefits Made Easy

Dearborn National

Payroll Deduction Form for Short Term Disability

26 Week Benefit

Benefits Begin: 15th Day for Accidents, 15th Day for Sickness

Monthly Premium Based on Age

If Your Annual Salary is at Least:	You May Select a Weekly Benefit of:	Your Monthly Premium Would Be:							
		Under Age 40	Age 40 - 44	Age 45 - 49	Age 50 - 54	Age 55 - 59	Age 60 - 64	Age 65 - 69	Age 70+
$7,430	**$100/Week**	$7.59	$7.15	$8.25	$9.90	$11.99	$13.97	$14.30	$16.20
$11,140	**$150/Week**	$11.39	$10.73	$12.38	$14.85	$17.99	$20.96	$21.45	$24.30
$14,860	**$200/Week**	$15.18	$14.30	$16.50	$19.80	$23.98	$27.94	$28.60	$32.40
$18,670	**$250/Week**	$18.98	$17.88	$20.63	$24.75	$29.98	$34.93	$35.75	$40.50
$22,285	**$300/Week**	$22.77	$21.45	$24.75	$29.70	$35.97	$41.91	$42.90	$48.60
$26,000	**$350/Week**	$26.57	$25.03	$28.88	$34.65	$41.97	$48.90	$50.05	$56.70
$29,715	**$400/Week**	$30.36	$28.60	$33.00	$39.60	$47.96	$55.84	$57.20	$64.80
$33,430	**$450/Week**	$34.16	$32.18	$37.13	$44.55	$53.96	$62.87	$64.35	$72.90
$37,145	**$500/Week**	$37.95	$35.75	$41.25	$49.50	$59.95	$69.85	$71.50	$81.00
$40,860	**$550/Week**	$41.75	$39.33	$45.38	$54.45	$65.95	$76.84	$78.65	$89.10
$44,570	**$600/Week**	$45.54	$42.90	$49.50	$59.40	$71.94	$83.82	$85.80	$97.20
$48,285	**$650/Week**	$49.34	$46.48	$53.63	$64.35	$77.94	$90.81	$92.95	$105.30
$52,000	**$700/Week**	$53.13	$50.05	$57.75	$69.30	$83.93	$97.79	$100.10	$113.40
$55,715	**$750/Week**	$56.93	$53.63	$61.88	$74.25	$89.93	$104.78	$107.25	$121.50
$59,430	**$800/Week**	$60.72	$57.20	$66.00	$79.20	$95.92	$111.76	$114.40	$129.60
$63,145	**$850/Week**	$64.52	$60.78	$70.13	$84.15	$101.92	$118.75	$121.55	$137.70
$66,860	**$900/Week**	$68.31	$64.35	$74.25	$89.10	$107.91	$125.73	$128.70	$145.80
$70,575	**$950/Week**	$72.11	$67.93	$78.38	$94.05	$113.91	$132.72	$135.85	$153.90
$74,290	**$1000/Week**	$75.90	$71.50	$82.50	$99.00	$119.90	$139.70	$143.00	$162.00
$78,005	**$1050/Week**	$79.70	$75.08	$86.63	$103.95	$125.90	$146.69	$150.15	$170.10
$81,720	**$1100/Week**	$83.49	$78.65	$90.75	$108.90	$131.89	$153.67	$157.30	$178.20
$85,435	**$1150/Week**	$87.29	$82.23	$94.88	$113.85	$137.89	$160.66	$164.45	$186.30

I would like to enroll in the Short Term Disability Program _____ **Yes** _____ **No**

Printed Name: _____ **Signature:** _____

Health Services Administrators
Insurance Benefits Made Easy

Dearborn National

Payroll Deduction Form for Short Term Disability

52 Week Benefit

Benefits Begin: 15th Day for Accidents, 15th Day for Sickness

Monthly Premium Based on Age

If Your Annual Salary is at Least:	You May Select a Weekly Benefit of:	Your Monthly Premium Would Be:							
		Under Age 40	Age 40 - 44	Age 45 - 49	Age 50 - 54	Age 55 - 59	Age 60 - 64	Age 65 - 69	Age 70+
$7,430	**$100/Week**	$8.80	$8.71	$10.05	$12.06	$14.61	$17.02	$17.40	$19.70
$11,140	**$150/Week**	$13.20	$13.07	$15.08	$18.08	$21.91	$25.53	$26.10	$29.55
$14,860	**$200/Week**	$17.60	$17.42	$20.11	$24.11	$29.22	$34.03	$34.80	$39.40
$18,670	**$250/Week**	$22.00	$21.78	$25.14	$30.14	$36.52	$42.54	$43.50	$49.25
$22,285	**$300/Week**	$26.40	$26.14	$30.16	$36.17	$43.82	$51.05	$52.20	$59.10
$26,000	**$350/Week**	$30.80	$30.49	$35.19	$42.20	$51.13	$59.56	$60.90	$68.95
$29,715	**$400/Week**	$35.20	$34.85	$40.22	$48.22	$58.43	$68.07	$69.60	$78.80
$33,430	**$450/Week**	$39.60	$39.20	$45.24	$54.25	$65.74	$76.58	$78.30	$88.65
$37,145	**$500/Week**	$44.00	$43.56	$50.27	$60.28	$73.04	$85.09	$87.00	$98.50
$40,860	**$550/Week**	$48.40	$47.92	$55.30	$66.31	$80.34	$93.59	$95.70	$108.35
$44,570	**$600/Week**	$52.80	$52.27	$60.32	$72.34	$87.65	$102.10	$104.40	$118.20
$48,285	**$650/Week**	$57.20	$56.63	$65.35	$78.36	$94.95	$110.61	$113.10	$128.05
$52,000	**$700/Week**	$61.60	$60.98	$70.38	$84.39	$102.26	$119.12	$121.80	$137.90
$55,715	**$750/Week**	$66.00	$65.34	$75.41	$90.42	$109.56	$127.63	$130.50	$147.75
$59,430	**$800/Week**	$70.40	$69.70	$80.43	$96.45	$116.86	$136.14	$139.20	$157.60
$63,145	**$850/Week**	$74.80	$74.05	$85.46	$102.48	$124.17	$144.64	$147.90	$167.45
$66,860	**$900/Week**	$79.20	$78.41	$90.49	$108.50	$131.47	$153.15	$156.60	$177.30
$70,575	**$950/Week**	$83.60	$82.76	$95.51	$114.53	$138.78	$161.66	$165.30	$187.15
$74,290	**$1000/Week**	$88.00	$87.12	$100.54	$120.56	$146.08	$170.17	$174.00	$197.00
$78,005	**$1050/Week**	$92.40	$91.48	$105.57	$126.59	$153.38	$178.68	$182.70	$206.85
$81,720	**$1100/Week**	$96.80	$95.83	$110.59	$132.62	$160.69	$187.19	$191.40	$216.70
$85,435	**$1150/Week**	$101.20	$100.19	$115.62	$138.64	$167.99	$195.70	$200.10	$226.55

I would like to enroll in the Short Term Disability Program _____ **Yes** _____ **No**

Printed Name: _____ **Signature:** _____

Electronic Payment Request Form

New clients: Use this form if you wish to authorize HSA to deduct your initial payment and/or monthly payments directly from your checking account.

Client Information:

Client Name: _____ 6 Digit HSA Member #: _____

Select payment type:

- ☐ First month's payment
- ☐ Recurring monthly payment
- ☐ Both first month's payment and recurring monthly payment

If requesting recurring monthly payments, select date for withdrawals to start. All outstanding balances owed, including fees, will be transferred at that time.

- ☐ 15th of Current Month
- ☐ 24th of Current Month
- ☐ 15th of Next Month
- ☐ 24th of Next Month

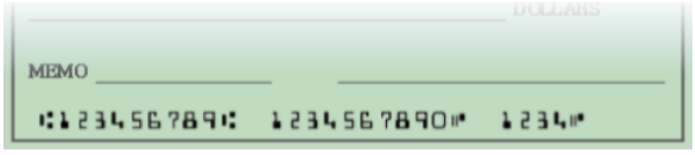
Bank Information:

Bank Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Name on Account: _____

Routing Number: _____ Bank Account Number: _____



Authorization:

I (we) hereby authorize HSA to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. Note: all written debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Authorized Signer _____ _____
Sign Name — Print Name and Title

Authorized Signer (if more than one required) _____ _____
Sign Name — Print Name and Title

Date: _____ Client Telephone: _____

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.