GROUP APPLICATION

Company Name: AELL - _____ Tax ID: _____

Key Contact: _____ Phone: _____

Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Billing Contact: _____ Phone: _____

Email: _____

PLAN INFORMATION

Effective Date: _____ New Hire Waiting Period: First of the month following ❑ 0 ❑ 30 ❑ 60 days from the date of hire Payroll Cycle: ❑ W ❑ BW ❑ SM ❑ M

Employer Contribution: ❑ None ❑ Set amount $_____ ❑ Percentage _____%

Other: _____

Do you have any members currently enrolled in COBRA? ❑ Yes ❑ No (If yes, please complete the takeover form from the link below) www.sbmabenefits.com/cobra

Do you utilize a COBRA TPA or self-administer COBRA? ❑ Yes ❑ No Total # eligible lives (all FTE): _____

MEDICAL PLAN OPTIONS

PENALTY A				PENALTY B
❑ BASIC	❑ VIRTUAL	❑ ULTRA	❑ ULTIMATE	❑ MINIMUM VALUE

ANCILLARY PLAN OPTIONS

DENTAL / VISION			WORKSITE		
❑ PREVENTIVE DENTAL	❑ COMPLETE DENTAL	❑ VISION	❑ HOSPITAL ONLY	❑ VALUE PACKAGE	❑ ADVANTAGE PACKAGE

VALUE ADD SERVICES

❑ PCORI Processing ❑ 1094 / 1095 Processing

ID CARD DISTRIBUTION

❑ Mail to member ❑ Bulk ship to employer

BROKER INFORMATION

Broker Name: _____ Tax ID: _____

Email: _____ Phone: _____

EMPLOYER ACKNOWLEDGMENT

Employer acknowledges the above information is accurate and will be utilized for the purpose of implementation and drafting the Administrative Services Agreement and other associated plan documentation. Policy terminations must be sent to SBMA on company letterhead, signed by the group administrator, and submitted prior to the effective date of termination.

Authorized Officer Name: _____ Title: _____

Signature: _____ Date: _____

Please email completed applications to newgroup@sbmabenefits.com

PAYMENT AUTHORIZATION

MAKING YOUR FIRST PAYMENT

SBMA requires your first payment be made electronically via Automated Clearing House (ACH). Following your initial payment, you may choose to make subsequent payments using any of the options provided on your invoice.

PAYMENT OPTIONS

You may choose to make only your first payment via ACH, or setup recurring Auto Pay and have all monthly invoices automatically paid on the 10th day of each month.

*****AUTO PAY PROMOTION*****
Groups who setup recurring Auto Pay will receive a $100 credit on the invoice following their first automatic payment.

- ❑ One-time automatic payment for your first invoice
- ❑ Recurring monthly payments for all invoices

BANKING INFORMATION

Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Grantee Name (as shown on account): _____

Your bank may require you to provide the following information: SBMA Company ID 5330903620

AUTHORIZATION

The client, by their signature below, authorizes Staff Benefits Management Inc. to automatically withdraw premium payment(s) based on the client's election above. If the recurring monthly payment option was chosen, this authorization will remain in effect until written request of termination has been provided by the client. Staff Benefits Management Inc., by its initiation of an authorized debit, hereby agrees to be bound by the National Automated Clearing House Association (NACHA) guidelines relating to Corporate Trade payment entries in the administration of these debit entries. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above-noted transaction date. In the case of the payment being rejected, I understand that SBMA may at its discretion, attempt to process the charge again within 30 days. I also agree to pay the $100 returned transaction fee for each attempt returned. The returned payment fee is for any bank charges and/or services in connection with processing the returned payment.

Authorized Representative: _____

Title: _____

Signature: _____ Date: _____