



P.O. Box 7777, Meridian, ID 83680-7777

## Case Issue Transmittal

**This form must be included with all new cases.** *Please complete this form in its entirety. An incomplete form may result in delayed processing.*

### I. GROUP & CONTACT INFORMATION

Group Effective Date: \_\_\_\_\_

New Group

Change – Existing Group

Group/Policy Number: \_\_\_\_\_

Group Name: \_\_\_\_\_ SIC Code: \_\_\_\_\_

(Please print clearly)

Group Contact Name: \_\_\_\_\_

Group Contact Email Address: \_\_\_\_\_

Billing Contact Name: (if different than above) \_\_\_\_\_

Billing Contact Email Address: \_\_\_\_\_

### II. GROUP ADMINISTRATION

#### A. Document Delivery – All documents will be issued electronically\* unless otherwise indicated below.

\*A welcome notice and instructions on accessing documents and Administrative Guides are e-mailed to the Group Administrator.

Group does not want documents sent electronically. Please indicate name and address materials should be sent to below.

Name: \_\_\_\_\_

Street Address (No P.O. Box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Additional copy of policy/certificates to be sent to: *(If additional space is needed, please provide in Comments section below.)*

Name: \_\_\_\_\_

Street Address (No P.O. Box) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If multiple classes, does the group want separate certificates by class  Yes  No

#### B. Billing Method (please select one below)

**Web Billing** – We provide initial enrollment details through our Web-based application which an employer can use to manage additions, changes, and terminations.

**Self-Administered** – All enrollment and individual coverage information is kept by the employer and only aggregate coverage information is provided to us monthly along with the premium due.

**List Billing** – Enrollment additions and deletions are managed by us and the bill is presented to the employer with individual enrollment information in paper form.

**Third Party Administration (TPA)** - If TPA, please provide TPA name: \_\_\_\_\_.

**Note:** If any units are to be billed separately: (1) indicate the name and address of each unit in the Comments section below or on an attachment; (2) state the amount of the premium deposit to be applied to each unit; and (3) separate enrollment forms by unit.



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#### III. COMMISSIONS

Commissions are payable to (Please check all that apply):

Broker Agency       Producing Agent

Commission Rate Payable: \_\_\_\_\_%

\*If more than one, list all others in Comments section and indicate split (please indicate Tax ID or SS# for each.)

The following information must be provided (please print):

Broker Agency (If applicable)  Yes     No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Tax ID or SS#: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_

Percentage of commission payable: \_\_\_\_\_%

AND/OR

Producing Agent  Yes     No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Tax ID or SS#: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_

Percentage of commission payable: \_\_\_\_\_%

#### IV. SUBMISSION CHECKLIST

- Application or Participation Agreement  Yes
- Completed Enrollment Forms  Yes (or census)
- Occupations and Earnings  Yes (required for all groups with STD/LTD coverage or salary based life coverage)
- Evidence of Insurability Form (if evidence is required)  Yes
- Deposit Premium (equal to one billing mode)  Yes
- Copy of Sold Proposal  Yes
- Producer Appointment Documents (if applicable)  Yes
- Copy of Prior Carrier's Plan  Yes (if available)
- Provide Schedule A information for form 5500 on groups over 100 lives  Yes     No



**UNITED  
HERITAGE**

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**V. PRODUCTION:** Please complete below.

	Employees # Elig/# Sold	Commissions*	Rate	Volume	Monthly Premium
Life	_____	_____	_____	_____	_____
AD&D	_____	_____	_____	_____	_____
Dependent Life	_____	_____	_____	_____	_____
STD	_____	_____	_____	_____	_____
LTD	_____	_____	_____	_____	_____
Supplemental Life/AD&D	_____	_____	Age	_____	_____
Supplemental Life-Spouse	_____	_____	Age	_____	_____
Supplemental Life-Children	_____	_____	_____	_____	_____
Voluntary Life - EE	_____	_____	Age	_____	_____
Voluntary Life - SP	_____	_____	Age	_____	_____
Voluntary Life - CH	_____	_____	_____	_____	_____
Voluntary STD	_____	_____	_____	_____	_____
Voluntary LTD	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Commission  
S = Standard\*

COMMENTS: