

## Transmittal Form

(Please Print)

Date Submitted: \_\_\_\_\_

**Fax form and apps to 866-621-3269**

**This form must be completed in detail and submitted with completed applications.**

1. Full Name of Business: \_\_\_\_\_
2. Business Industry: \_\_\_\_\_ SIC Code: \_\_\_\_\_
3. Business Address: \_\_\_\_\_  

ADDRESS
CITY
STATE
ZIP
4. Billing Address: \_\_\_\_\_  

ADDRESS
CITY
STATE
ZIP
5. Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_
6. Phone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

***Additional information needed for Short-Term Disability:***

1. Occupation Class: \_\_\_\_\_ Eligible Employees: \_\_\_\_\_
2. Is other Employer sponsored VSTD being replaced?      YES      NO
3. If YES, to secure pre-ex credit please provide a copy of the LATEST BILL along with the name of the Carrier: \_\_\_\_\_
4. If Employer LTD is in place: Elimination Period \_\_\_\_\_ months % of Salary \_\_\_\_\_

7. Policy Effective Date: Month: \_\_\_\_\_ 1<sup>st</sup> or 15<sup>th</sup>

8. Applications are:      New Case      Additions      Re-Enrollment

9. Mail Policies to:      Agent      Group      Employee

10. Primary Agent:

Name	Agent Number	% of Commission

11. Secondary Agent:

Name	Agent Number	% of Commission

**Please complete and attach your payroll deduction form**