

New Group Submission Checklist

Group Name: _____

Contact: _____

Contact Email: _____

Contact Phone: _____

Thank you for selecting the Defend Plans. Please email as attachments the following forms to Sales@InsurgencyBenefits.com.	
For Employers and Employees	
<input type="checkbox"/>	Employer Application Please be thorough and do not leave questions blank or unanswered. If a question doesn't apply enter "N/A."
<input type="checkbox"/>	Rate Sheet(s) Please sign and date rate sheets from your quote for the plans sold. Please do not send all proposed plans.
<input type="checkbox"/>	Current Carrier Billing Please include the latest invoice available
<input type="checkbox"/>	Employee Enrollment Forms Please verify thorough completion of all forms and that your desired effective date is indicated.
<input type="checkbox"/>	Defend Plans Employer Acknowledgements of Disclosures Please sign and date this document certifying the employer (Plan Sponsor) has reviewed the implications of self-funding.
<input type="checkbox"/>	Wage and Tax Report Most recent filing. Please reconcile this report by indicating which employees are enrolling, ineligible or declining.
<input type="checkbox"/>	COBRA For Current Participants please provide: Member demographics, copy of COBRA Election Form, Qualifying Event Date, Qualifying Event Reason, Coverage being selected, Premiums paid through date Will group have any stand-alone COBRA administration. <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", indicate coverages (dental, vision) and the stand-alone COBRA rates to be used for the new effective date.
<input type="checkbox"/>	Claims History: If not provided previously. Please submit, for the past two years if available, medical and pharmacy claims experience and information concerning all claims over \$25,000. For groups providing two years of claims experience only, employees may skip medical questions (Section 7 of the Defend Plans Employee Application)
<input type="checkbox"/>	Additional Information As requested by the underwriter, if any.

IMPORTANT NOTE:

DO NOT CANCEL CURRENT COVERAGE UNTIL WRITTEN CONFIRMATION OF APPROVAL IS RECEIVED FROM THE DEFEND PLANS UNDERWRITERS.

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<input type="checkbox"/>	<p>Mail Check for First Month Fees (Payable to Acuity Group) to: <i>Billing Department, Acuity Group, 1022 Highland Colony Parkway, Ridgeland, MS 39157</i></p> <p>Attach Copy of this Check to Employer Application</p> <p><i>Note: Client should not include payments for current COBRA participants</i></p>
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	For Brokers
	<i>When submitting your first Defend Plan case or your first case with this Stop-Loss Carrier, please submit the following:</i>
<input type="checkbox"/>	W-9 Form
<input type="checkbox"/>	<p>Insurgency Benefits Producer Agreement and Exhibits</p> <p>Available from your general agent or through Sales@ProtectPlan.Info</p>
<input type="checkbox"/>	Copy of Current E&O Policy
<input type="checkbox"/>	<p>Stop-Loss Carrier Forms</p> <p>If this is your first case with this stop-loss carrier. Forms are on the web site.</p>

Next Steps:

Please submit your client’s application and other material to Sales@InsurgencyBenefits.com. Insurgency Benefits, the program underwriter, or the program administrator may contact you for additional information. If approved for coverage, the administrator will provide your group with ID Cards and Plan Documents.

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