Product and Benefit Selection Form (1-99)

*** The plans you select on this form will be the plans you are locked into for the policy year.
No plans can be added or changed until your renewal the following year.

1. Group Name _____ Effective Date _____

2. Medical Plan Code(s)

_____ _____
_____ _____
_____ _____
_____ _____

3a. Dental Plan Code(s)

_____
_____

3b. Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No
If yes, name of carrier _____
☐ Prior Carrier Invoice ☐ Copy of Current/Prior Benefits

4. Vision Plan Code

_____

5. Life Amount(s) in dollars

Employee* _____
Spouse _____
Child(ren) _____

Acceptance of this application will replace existing life insurance coverage. ☐ Yes ☐ No
*25K minimum life amount required to qualify for packaged savings for a life /medical sale

6. Supplemental Coverage(s)

Sup Life _____
STD _____
LTD _____
Accident** _____
Critical Illness** _____

**Limited Availability

7. Please indicate if the group wants paper or electronic billing (Note: Hard copies of the bill may still be printed out from www.employereservices.com)

8. Required Documents for Case Installation Checklist

- ☐ Employer Group Application
- ☐ Employee Applications or Enrollment Spreadsheet(for all full time eligible employees)
- ☐ Direct Debit Form Or Copy of Initial premium Check
- ☐ Quarterly Wage & Tax and Ownership Paperwork (Schedule C, K1 - if owners enrolling and not on W&T)
- ☐ Product selection form (this form)

Signature

Employer Signature	Title	Date