

Medical Sold Case Summary Checklist

Group Name: _____ Eff. Date: _____

Account Executive: _____

- | | | | |
|----|--|--------------------------|--------------------------|
| | | Yes | No |
| 1. | Are you selecting a "Premium Only Sec 125 Plan" with Ceridian Benefit Services?
(If yes, include application) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Does this group have out-of-state employees not applying?
If YES, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

INDICATE APPROPRIATE PLAN CODE SELECTIONS BELOW

Medical Plan Code(s):	AND	Pharmacy Plan Code(s):
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Option 1 – Base Location*: _____

PT-___ NA - ___ US-___ OTHER _____

RX Plan Code: _____

Option 2 – Additional Employee Locations	Total # of Locations: _____
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Location 1: _____ RX Plan Code: _____

NA-___ US-___ Other - _____

Location 2: _____ RX Plan Code: _____

NA-___ US - ___ Other - _____

Location 3: _____ RX Plan Code: _____

NA-___ US - ___ Other: - _____

Option 3 – Dual Option Plans

PT-___ NA-___ US - _____ RX Plan Code: _____

and _____ and _____

PT-___ NA-___ US - _____ RX Plan Code: _____

***The base location is where the plurality of employees resides. (If only one location, skip Option 2)**

<p>Optional 24 hour coverage</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">For owners and partners only</p> <p>Note: Additional premium required for Rider</p> <p>Infertility Rider <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Automatic Bank Draft</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">Pls complete ACH form and attach voided check</p>	<p>Consumer Choice Option (CCO)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach CCO forms for Enrolling employees. NOTE: 17% additional premium required.</p> <p>Obesity Rider <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Note: Additional Premium required for Rider</p>
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By signing below, the undersigned agrees that the above selected benefits will be provided for the members of the employer group. Such selection(s) will be incorporated into the Group Policy and Certificate, which are the governing documents. In addition, I verify that all employees applying for or waiving coverage are eligible to do so. Preliminary rates will be adjusted to reflect actual enrollment and underwriting risk assignment for final rates: Rates are not final until the Final Confirmation Form is returned.

Group Administrator _____ (Signature) _____ Date

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.