



**GAPP I.** **GAPP II.** **TAPP.** **ENROLLMENT CHECKLIST**

**Group Accident Protection Plan**

Employer Name: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_  
 Email: \_\_\_\_\_

Primary Producer / Agent Name: \_\_\_\_\_ Commission %: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tax ID# \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

Co-Producer / Agent Name: \_\_\_\_\_ Commission %: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tax ID# \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

General Agent's Name: \_\_\_\_\_ Commission %: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tax ID# \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

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

Special Instructions: \_\_\_\_\_  
 \_\_\_\_\_

- Included Are:    \_\_\_\_\_ Employer Application for Coverage  
                   \_\_\_\_\_ Proposal  
                   \_\_\_\_\_ Producer / Agent Licensing Madison National Life - Occupational Accident  
                   \_\_\_\_\_ Producer / Agent Licensing Independence American - Employer Liability, if applicable  
                   \_\_\_\_\_ Premium Check in the amount of \$ \_\_\_\_\_  
                   \_\_\_\_\_ Owner Waiver, Contract Labor and Employee Census Form  
                   \_\_\_\_\_ ERISA Plan Worksheet  
                   \_\_\_\_\_ Agreement for Electronic Funds Transfer

**Please Note:** For electronic ACH premium payments, please submit one full month's premium with your application. This payment will be pro-rated to the first of the following month. An adjustment, if applicable, will be made on the next month's billing statement. ACH payments are drafted on the 5th of each month.

**Marketed By: George W. Evans & Associates, Inc.**  
 Send Completed Enrollment Material to: 5904 Dolores, Houston, TX 77057-5604  
 (800) 580-3826 or (713) 780-1116                      Fax: (713) 782-1113                      gapp@gwevans.com

**Administered by: North American Benefits Company (NABCO)**  
 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355                      (800) 994-GAPP (4277)                      Enrollment Checklist



# MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • Phone: 1-800-356-9601

Administrative Office: (NABCO) 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

## GROUP ACCIDENT PROTECTION PLAN APPLICATION FOR COVERAGE – GAPP II

1. Legal Name of Applicant: \_\_\_\_\_  
 DBA: \_\_\_\_\_ Federal Tax ID Number: \_\_\_\_\_
2. Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_
3. Physical Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
5. Email Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_
6. Business is:  Corporation  LLC  Sole Proprietorship  Other (explain): \_\_\_\_\_
7. How long has Applicant been in business? \_\_\_\_\_ What are hours of operation? \_\_\_\_\_
8. Describe nature of business: \_\_\_\_\_
9. What date was the Workers' Compensation Act rejected? \_\_\_\_\_
10. Does Applicant or its affiliate(s) manufacture, store, distribute, sell, handle or transport any of the following?  
 Chemicals  Yes  No Details: \_\_\_\_\_  
 Pharmaceuticals  Yes  No Details: \_\_\_\_\_  
 Fuel Oils  Yes  No Details: \_\_\_\_\_  
 Hazardous Materials  Yes  No Details: \_\_\_\_\_  
 Nuclear Materials  Yes  No Details: \_\_\_\_\_  
 Asbestos Materials  Yes  No Details: \_\_\_\_\_
11. Has Occupational Accident and/or Employer Liability Insurance ever been canceled, refused or non-renewed by any company during the past three (3) years?  Yes  No If Yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_
12. Does Applicant or its affiliate(s) perform any work at heights taller than 10 feet? If Yes, please provide details: \_\_\_\_\_
13. What percentage of loads are manually loaded or unloaded (enter 0% if none): \_\_\_\_\_% Loaded \_\_\_\_\_% Unloaded
14. Does Applicant or its affiliate(s) currently have any open Employer Liability or Occupational Accident claims?  Yes  No If Yes, please provide details: \_\_\_\_\_
15. With regard to occupational injury and illness, has the Applicant or its affiliate(s) ever:  
 Received a citation, warning or judgement?  Yes  No  
 Been fined, sued or settled an occupational injury or employer liability claim?  Yes  No  
 Paid an award or judgement?  Yes  No  
 If Yes, please provide details: \_\_\_\_\_

16. Please submit three years loss history with this Application.

17. Does the Applicant currently have an ERISA Plan they wish to continue?  Yes  No If Yes, please provide a copy of the complete Plan Document, including the Summary Plan Description. It must be approved in writing by the Company prior to use.

18. Are any affiliated entities to be covered?  Yes  No If Yes, please provide Legal Names and Addresses:

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Please specify number of employees at each location: \_\_\_\_\_

19. Are multiple locations or job sites to be covered?  Yes  No If Yes, please provide Addresses:

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Please specify number of employees at each location: \_\_\_\_\_

20. Are owners, officers or partners to be covered?  Yes  No If Yes, do they appear on the State Employment Commission Report?  Yes  No

Please list the owners, officers or partners that are to be excluded from coverage: \_\_\_\_\_

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21. Policy Elections:

• Deductible Type:

- Aggregate Deductible (\$2,500 min/ \$50,000 max): \$ \_\_\_\_\_
- Individual Deductible - per covered person per occurrence (\$1,000 min/ \$50,000 max): \$ \_\_\_\_\_

• Combined Single Limit - per covered person per occurrence (\$100,000 min/ \$3 mill max): \$ \_\_\_\_\_

• Aggregate Limit of Liability - per occurrence :

\$5 mill

• Accumulation Period (weeks):

52  110  156

• Weekly Indemnity:

- Elimination Period (days):  7  14

- Benefit Amount (% of weekly wage):  75%  Other, please list (50% min/ 75% max): \_\_\_\_\_%

- Maximum Weekly Indemnity:  \$750  Other, please list (\$200 min/ \$800 max): \$ \_\_\_\_\_

- Maximum Weeks Duration (weeks):  same as Accident Medical

• Accidental Death, Dismemberment and Loss of Use:

\$150,000  Other, please list (\$100,000 min/ \$500,000 max): \$ \_\_\_\_\_

10 times employee salary (max \$500,000)

• Occupational Disease, Cumulative Trauma and Occupational Hernia (subject to policy limits):

Included

• Include Waiver of Subrogation:  Yes  No

• Include Alternate Employer Endorsement:  Yes  No



22. Premium Calculation and Payment Mode:  Monthly Bill

NCCI Code	Class Description	Payroll, including tips	Payroll Rate	Total for Class
Total Payroll				
Composite Rate				
Premium Subtotal:				
Monthly Admin / Billing Fee:				\$60
One-Time Issue / Policy Fee:				\$100
One-Time ERISA Set-Up Fee*:				
Monthly ERISA Maintenance Fee*:				
<b>Initial Payment:</b>				

\* Applicable when Employer liability coverage is selected.

*(Please make premium check payable to Administrator, NABCO)*

THE INFORMATION ABOVE ACCURATELY REPRESENTS: 1) THE GAPP PLAN FOR WHICH WE ARE APPLYING, AND 2) THE REQUIRED EMPLOYEE INFORMATION.

\_\_\_\_\_  
Employer Authorized Signature

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Broker or Agent Name (please print)

\_\_\_\_\_  
Broker or Agent Signature

\_\_\_\_\_  
Signature Date

**THE EMPLOYER CERTIFICATION (FORM NUMBER OCC ACC APP CERT 1016) MUST BE COMPLETED AND SUBMITTED WITH THE APPLICATION FOR THE COMPANY TO ISSUE A POLICY.**

# INDEPENDENCE AMERICAN INSURANCE COMPANY

a Delaware Insurance Company

Home Office: 485 Madison Avenue, 14<sup>th</sup> Floor, New York, NY 10022

Administrative Office: (NABCO) 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

## Employers Liability Coverage Election Form

Election is hereby made for the coverage specified to become effective on: \_\_\_\_\_ at 12:01 A.M. Central Standard Time at the address described below and provided that the initial premium is paid in full and the Company approves the coverage.

1. Legal Name of Employer: \_\_\_\_\_

DBA: \_\_\_\_\_ Federal Tax ID Number: \_\_\_\_\_

2. Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Email Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

3. Physical Address: \_\_\_\_\_

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

4. Mailing Address: \_\_\_\_\_

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

5. Policy Elections:

• Deductible per Occurrence:  \$1,000  \$2,500  \$5,000  \$10,000

• Maximum Amount of Indemnity per Occurrence:  \$10,000  \$25,000  \$50,000

6. Premium Calculation and Payment Mode:  Monthly Bill

NCCI Code	Class Description	Payroll	Payroll Rate, including Tips	Total for Class
Total Payroll				

Composite Rate \$

Initial Payment \$

*Please make premium check payable to "North American Benefits Company."*

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

As per the policy provisions, we have the right to audit your payroll records at any time. If it is determined that premiums have been unpaid, we shall be entitled to recover such underpayments.

1. The Employer requests coverage for a policy of insurance as described above. The Employer also agrees to be bound by all of the terms, conditions and exclusions of the policy. The Employer further understands and agrees that:
  - a. Neither the Request for Coverage, nor the payment of any monies to be applied, shall guarantee insurance to become effective. In order for insurance to take effect on the date specified, the "Company" must accept and issue a policy.
  - b. The Insured/Employer will agree to pay the required premiums to the Company when due.
2. Acceptance of this request is subject to all of the following: (a) Company's requirements; (b) Terms of the Policy; (c) Company verification of the quoted premium.
3. The Company will notify the Insured/Employer of any approval or disapproval of this request. Any notice/binder of approval will specify the policy effective date and schedule of coverage.
4. The undersigned Insured/Employer understands that he/she may be subject to on-site loss control/safety inspections. Periodic loss control/safety inspections may be required as a contingency for continuation of coverage. The Insured/Employer also understands and agrees that he/she will be required to comply with any/all loss control/safety recommendations as a contingency for continuation of coverage.
5. The undersigned Insured/Employer has reviewed with his agent (who signs below) and understands the coverage, limits, terms, conditions and exclusion of this application and the Policy.
6. The Employer shall make modified duty available for employees approved for rehabilitation and able to return to some form of work as agreed to by the employee's treating physician.
7. The undersigned Insured/Employer understands coverage is written on a Combined Single Limit basis. All coverage afforded under this policy shall not exceed the coverage amount specified for any one person or occurrence per the policy terms and conditions.
8. This is not Workers' Compensation Insurance, nor is it a replacement for Workers' Compensation Insurance. Independence American Insurance Company does not sell, nor is it authorized to sell, Workers' Compensation Insurance.

Employer Signature (Officer): \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned agent warrants he/she has not represented the above coverage as anything other than an Occupational Accident policy for on-the-job employee-related injuries.

Agent of Record: \_\_\_\_\_ Date: \_\_\_\_\_

Agency/Recording Agent Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

License I.D. Number: \_\_\_\_\_

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

## Disclosure and Acknowledgement Concerning Workers' Compensation

This will acknowledge that in solicitation of the Independence American Insurance Company Employers Liability Insurance Policy, the Agent named below (herein referred to as "Agent"), explained to me the following facts about the Texas Workers' Compensation Act (the "Act"). The following facts were discussed, and as an employer I am aware of their importance. To my knowledge, no statements contrary to the following statements were made by the Agent to anyone employed by or representing me.

1. Workers' compensation insurance is a "No-Fault" system that affords coverage for my employees and protections for me which no alternative insurance plan can duplicate.
2. It is my responsibility, should I elect not to purchase workers' compensation insurance, to notify the Texas Department of Insurance, Division of Workers' Compensation ("DWC") at the time of such election by filing the appropriate form (currently the DWC Form 5). I must also annually file the appropriate form (currently DWC Form 5) with the DWC on the anniversary date of the original filing or if I have canceled my workers' compensation policy, on the anniversary of the cancellation date of the workers' compensation policy. I am aware of the penalty for failure to properly file can be as much as \$25,000 per day. I also must notify my workers' compensation carrier, in the manner provided by the law, at the time of my election. All notices and elections must be made by certified mail, return receipt requested.
3. Agent has advised me that if I become a non-subscriber under the Act, I should seek the advice of competent legal counsel in meeting the provisions of the Act. Agent has advised me to seek legal advice for the current law as it applies to my situation.
4. I am aware that as a non-subscriber, should I purchase an alternative insurance product that provides occupational injury benefits for my employees, I may come under the Employee Retirement Income Security Act of 1974 (ERISA). I understand that it may be in my best interest to have a written occupational injury benefit plan, and to file this plan under ERISA with the U.S. Department of Labor. Such insurance and plan do not preempt a personal injury negligence lawsuit.
5. I understand that a safety program could help reduce the frequency and severity of on-the-job injuries and could also help me meet my responsibility to provide a "reasonably safe place to work" for our employees.

I acknowledge the option I have selected is solely my choice and the alternative plan I have chosen was not represented by Agent to any person as being a substitute for statutory workers' compensation insurance. Agent did not induce me or any representative of my company to reject Workers' Compensation. I have sought, or been given the opportunity to seek, competent legal counsel to advise me on this decision.

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

I read the above and acknowledge Agent has discussed each of these items with me.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Employer Name (please print)

\_\_\_\_\_  
Agent Name (please print)

\_\_\_\_\_  
Signature – Officer/Owner

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Name and Title (please print)

**EMPLOYER CERTIFICATION  
TO GROUP ACCIDENT PROTECTION PLAN APPLICATION**

**THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS CERTIFICATION IS  
COMPLETED AND SUBMITTED WITH THE APPLICATION**

We, the undersigned Employer, hereby certify the following:

1. We are applying to Madison National Life Insurance Company, Inc. (the Company) for Accident Insurance. We fully acknowledge and understand that acceptance of this request is subject to all of the Company's requirements and verification of quoted premium. The insurance applied for shall not be effective until the application has been approved and accepted by the Company in writing and the Coverage Effective Date has been assigned. A Policy and Schedule of Benefits will be issued.
2. We understand that 100% of all eligible employees must be covered and that this will be verified using quarterly employment tax statements.
3. In order for employee insurance to take effect, each employee must satisfy the eligibility requirements of the Policy.
4. We agree to pay the required premiums to the Company when due.
5. We have reviewed the sales material and the application. These materials, taken together, describe the coverage terms explained to us by the broker/agent whose signature appears below.
6. We understand the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying.
7. WE ACKNOWLEDGE AND FULLY UNDERSTAND EACH OF THE FOLLOWING ITEMS:
  - a. The coverage for which application being made is an employee benefit and does not insure any casualty or general liability risk of the Employer. This coverage is not intended to nor will it provide the Employer with any protection or defense against any suit which may be brought by an employee or anyone else.
  - b. Neither the Company nor the undersigned broker/agent has represented the coverage as anything other than an employee benefit which offers no indemnity for the Employers' liability.
  - c. THIS IS NOT A PROGRAM OF WORKERS' COMPENSATION INSURANCE. WE DO NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS COVERAGE. AND IF WE ARE A NONSUBSCRIBER, WE LOSE CERTAIN COMMON LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. WE MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.
8. I am authorized by the Employer to review and to sign this Certification.
9. Madison National Life Insurance Company, Inc. and its representative are authorized to contact me by mail or telephone to discuss this certification.

**THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.**

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Employer Authorized Signature

Title

Date

---

Broker or Agent Signature

Printed Name of Agent

Date





# GAPP I. GAPP II. TAPP. GROUP ACCIDENT PROTECTION PLAN

Check One:  GAPP I  GAPP II  TAPP

## Owner/ Officer Waiver, Contract Labor and Employee Census Form

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

Prepared By: \_\_\_\_\_ Date: \_\_\_\_\_

Are Officers, Owners and/ or Partners to be covered?:  Yes  No

If No, please list individuals to be excluded from coverage:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Census

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

If additional space is needed, please use the Employee Census Supplemental Form.

I certify \_\_\_\_\_ the above information is accurate and agree that wages are subject to verification and audit.  
 (Signature of Employer Representative)

Please complete this form when any new additions or terminations occur with your statement.

Return to: NABCO  
 Attn: GAPP  
 20 Valley Stream Parkway, Suite 310  
 Malvern, PA 19355



# GAPP I.

# GAPP II.

## ERISA PLAN WORKSHEET

**This form must be completed for GAPP I and GAPP II with Employer Liability**

Employer Legal Name: \_\_\_\_\_

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

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

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

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

Phone: (     ) \_\_\_\_\_ Fax #: \_\_\_\_\_

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

Federal Tax I.D. No.: \_\_\_\_\_

Employer's fiscal year ends: \_\_\_\_\_

Employer is:         Corporation         Sole Proprietorship         Partnership

Affiliated or subsidiary companies covered?    Yes    No   % \_\_\_\_\_ Common Ownership  
(Attach additional sheets showing above information for each entity and indicate % of ownership)

Name and Title of ERISA Plan Administrator:

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Number of Employees: \_\_\_\_\_

Effective Date of ERISA Plan: \_\_\_\_\_

Do you currently have any existing Employee Welfare Benefit Plans, which are governed by ERISA?

(I.E. Group Health Insurance)?    Yes    No

If yes, please specify Plan I.D. Number(s): \_\_\_\_\_

Describe each Plan: \_\_\_\_\_

Producer Agent:

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

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

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



GAPP I.

GAPP II.

TAPP.

# GROUP ACCIDENT PROTECTION PLAN

## Employee Census Supplemental Page.

### Census

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

I certify \_\_\_\_\_ the above information is accurate and agree that wages are subject to verification and audit.  
 (Signature of Employer Representative)

Please complete this form when any new additions or terminations occur with your statement.

Return to: NABCO  
 Attn: GAPP  
 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

## Recurring Credit Card Payments

### Procedures

- Any policyholder who elects Recurring Credit Card payments is required to complete an Authorization Form (See attached).
- The policy will have a 1<sup>st</sup> of the month billing date.
  - If the effective date of the policy does not fall on the first of the month, the initial credit card payment will be pro-rated to the first of the month.
    - Example:
      - Effective date 1/15/17.
      - Initial credit card payment will be for the billing period of 1/15/17 through 2/28/17.
      - The next payment due date will be 3/1/17.
- The policyholder will receive the attached instructions with each subsequent invoice.
- The subsequent invoices will be mailed the 15<sup>th</sup> day of each month prior to the group's next 1<sup>st</sup> of the month due date.
- The policyholder will be instructed to complete their monthly invoices by reflecting any changes to the number of lives, payroll, and premium.
- The completed invoice must be emailed to Nabco by the 5<sup>th</sup> day of each month.
  - Example:
    - The 2/1 invoice will be mailed to the policyholder on 1/15.
    - The policyholder must update the number of lives, payroll, and premium due and email the completed invoice by 2/5 to Nabco.
    - Email Address: [gappptd@nabenefits.com](mailto:gappptd@nabenefits.com)

**The completed invoice will authorize Nabco to charge the updated premium due to the credit card maintained on file.**

- If the invoice is not received, Nabco will process the current monthly premium based on the prior months reported lives, payroll, and paid premium.
- NABCO will charge the credit card maintained on file on the 10th calendar day of each month for the premium due.
- A payment receipt will be emailed to the policyholder.
- If payment is rejected, Nabco will contact the policyholder for payment.
- If a replacement credit card is not available, a check payment will be required and the group will be removed from the automatic credit card billing.



NORTH AMERICAN BENEFITS COMPANY  
 20 Valley Stream Parkway, Suite 310  
 Malvern, PA 19355  
 800-994-4277

### Credit Card Recurring Payment Authorization Form For Occupational Accident Policy

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

**Recurring Payments Will Make Your Life Easier:**

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town)

**Here's How Recurring Payments Work:**

- You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card.
- You will be charged each billing period for the total amount due for that period.
- You agree to email the completed billing statement to NABCO @ [gappptd@nabenefits.com](mailto:gappptd@nabenefits.com) by the 5<sup>th</sup> of each month. This billing statement notification will authorize NABCO to charge the premium amount due to your credit card.
- Once your payment is submitted, a receipt will be emailed to you and the charge will appear on your credit card statement.

**Please complete the information below:**

I \_\_\_\_\_ authorize North American  
 (Please Print Full Name & Title)

Benefits Company to charge the credit card indicated below on the **10th** calendar day of each month for payment of my assigned Occupational Accident Policy.

Policyholder Name \_\_\_\_\_ Policy # \_\_\_\_\_

Credit Card Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Account Type:  Visa  MasterCard  Amex  Discover

Cardholder Name \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next following business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

*North American Benefits Company  
20 Valley Stream Parkway  
Suite 310  
Malvern, PA 19355  
1-800-994-4277*

***TO OUR OCCUPATIONAL ACCIDENT PROTECTION PLAN POLICYHOLDERS***

***RECURRING CREDIT CARD INSTRUCTIONS***

- *Enclosed please find your modal billing statement for your current Occupational Accident Policy.*
- *Please return the completed billing statement along with a completed Report of Change or Contract Labor Census (if it pertains to your policy) to ensure that we have the most accurate data.*
- *Email completed billing statement to NABCO at [gappptd@nabenefits.com](mailto:gappptd@nabenefits.com) by the 5<sup>th</sup> of each month.*

***On the 10<sup>th</sup> of each month, NABCO will charge the Credit Card that is currently maintained on file the total amount based on the billing statement submitted to us by the 5<sup>th</sup> of each month.***

***If no changes are received, NABCO will process the current monthly premium based on the prior months reported lives, payroll, and paid premium.***

*Please feel free to contact your NABCO account manager if you have any questions or concerns.*