Globe Life
Liberty National Division

Worksite Advantage

Section 125

Required Forms Packet

Agent _____

AO Number _____ **Agency Number** _____

Agency Owner _____

Company _____

Attach all forms and employee list to the Worksite Account in EPIC.
Tag (@WorksiteApproval) for all communication concerning the Worksite Account.
Tag (@FranchiseActivity) when attaching an updated employee list.

EMPLOYEE ENGAGEMENT PROCESS

The most important part of a successful benefit enrollment is 100% participation by all employees. This benefits you in three ways. (Please initial)

_____ **1. Tax Savings:** The more employees that participate in the plan by purchasing pre-tax products, the greater your tax savings as an employer. This works by reducing the amount of taxable payroll on which you pay Federal Insurance Contribution Act (FICA) tax and Federal Unemployment Tax Act (FUTA).

_____ **2. Employee Goodwill:** As discussed, we will provide an Accidental Death Policy to all eligible employees with no cost to them for the first policy year. We will also provide a Health Savings Discount card to all eligible employees at no cost. We will make sure your employees know that these benefits are being made available on your behalf.

_____ **3. Compliance:** Our goal is to make sure your plan stays in compliance with Section 125 guidelines. Your plan stays in compliance when you ensure that all employees have an opportunity to participate in the benefits.

Enrollment Date(s): _____

Enrollment Start Time: _____

Contact Person Day of Enrollment: _____

Person Who Will Receive Deduction Authorizations: _____

Enrollment Location: _____

☐ Employee List With Names And Hire Dates

☐ Employer Verification Call

Location Checklist

☐ Private location to discuss HIPAA sensitive health questions

☐ Easily accessible to all employees

☐ Table, chairs, power outlet, etc.

WORKSITE ADVANTAGE — Payroll Deduction Billing Information Sheet

COMPANY INFORMATION

Name of Company _____ Account # _____ Phone Number ( ) - _____ Fax Number ( ) - _____ Total # Eligible Employees _____

Company Billing Address _____ City _____ State _____ ZIP _____

Company Physical Address (if different from billing address) _____ City _____ State _____ ZIP _____

Employer/Owner/Decision-Maker _____ Phone Number ( ) - _____ Email Address _____

Company Billing/Payroll Contact (Person who handles deductions) _____ Phone Number ( ) - _____ Email Address _____

Does Company use ❑ payroll company or ❑ accountant?

Payroll Company or Accountant (if applicable) _____ Phone Number ( ) - _____ Email Address _____

BILLING INFORMATION

1. Premiums are deducted: (check one)
   ❑ **weekly** *(52)* ❑ **bi-weekly** ❑ **semi-monthly** ❑ **monthly**

2. Payments will be sent: (check one)
   ❑ **weekly** *(52)*
   ❑ **bi-weekly** *(26)*
   ❑ **semi-monthly** *(24)*
   ❑ **monthly** *(12 bills)*
   ❑ **monthly** *(12 bills -4/4/5) Circle Payroll Deduction Day of the week* ☐☐☐ ☐☐☐ ☐
   ❑ **monthly** *(12 bills -2/2/3) Fill in the Employer's 1st payroll deduction of the calendar year* 01 (mm) ___ (dd) ___ (yyyy)
   ❑ **semi-monthly** *(20 bills) govt/schools*
   ❑ **9 monthly** *(9 bills) govt/schools*
   ❑ **10 monthly** *(10 bills) govt/schools*
   ❑ **every 4 weeks** *(13 billings per year) Requires senior management approval*

3. Request Online Billing ❑ **Yes** ❑ **No**

4. Type of Business (Give Details) _____

5. Date Company was established ___ (mm) ___ (yyyy) (Must be at least 1 year old)

6. Enrollment Period From ___ (mm) ___ (dd) Through ___ (mm) ___ (dd)

   First Deduction Date ___ (mm) ___ (dd) ___ (yyyy) Policy Effective Date ___ (mm) ___ (dd) ___ (yyyy)

7. Employees should be listed on billing in what order? (check one) ❑ **Alpha** ❑ **SS#** ❑ **EE#**

8. Are any of the employees leased? ❑ **Yes** ❑ **No**

SECTION 125 SPECIAL INFORMATION

1. Are existing Payroll Deduction policy premiums being redirected to allow pre-tax salary reductions? ❑ **Yes** ❑ **No**
   If "yes," premiums must be shown on the employee's election forms and employees listed on the New Business form.

2. Section 125 policies should be billed: ❑ **on the same billing as other policies** ❑ **on a separate billing**

AO #: _____ Agent Number: _____ Agency Number: _____

Liberty National Life Insurance Company
Section 125 Premium Only Plan

PLAN ADOPTION AGREEMENT

Instructions to Employer:

You must complete, sign, and date this Plan Adoption Agreement in order to adopt the Liberty National Life Insurance Company Premium Only Plan. The Plan, once adopted, will become effective as of the date you specify below in item #3. Do not specify an effective date earlier than the first day of the payroll period beginning after the day on which you sign the Plan Adoption Agreement.

1. Employer's full name: _____

2. List any affiliated employers or other office locations, if any, who will participate in the Plan Enrollment:

	Employer	Address	City	State	Zip
A.	_____	_____	_____	_____	_____
B.	_____	_____	_____	_____	_____
C.	_____	_____	_____	_____	_____
D.	_____	_____	_____	_____	_____

3. Effective Date: _____ (mm/dd/yyyy)

4. Plan Year:
   - ❑ The twelve month period commencing on _____ (mm/dd) and ending on _____ (mm/dd).
   - ❑ The first Plan Year shall be a short Plan Year beginning on _____ (mm/dd/yyyy) and ending on _____ (mm/dd/yyyy).

5. Franchise number: _____

6. Employees shall be considered to work full-time if they work at least _____ hours per week **[specify minimum number of hours].**

7. Liberty National Life Insurance Company Qualified Benefit Plans shall mean:
   - ❑ Liberty National Division Cancer Insurance
   - ❑ Liberty National Division Group Term for Life Insurance
   - ❑ Liberty National Division Dental Alternative
   - ❑ Liberty National Division Vision Plan
   - ❑ Liberty National Division Hospital Intensive Care Insurance
   - ❑ Liberty National Division Accident Protector Max Insurance
   - ❑ Liberty National Division Accident Plan Insurance (ACB)

8. Employer's Qualified Benefits to be included in the Plan are:
   - ❑ Employer's Group Term Life Plan
   - ❑ _____
   - ❑ Employer's Group Health Plan
   - ❑ _____

PAYROLL DEDUCTION AGREEMENT

BETWEEN

LIBERTY NATIONAL LIFE INSURANCE COMPANY

AND

_____

COMPLETE NAME OF EMPLOYER (FIRM)

For the benefit and convenience of its employees, _____, (hereinafter referred to as the "Employer") agrees to provide for payroll deduction for insurance by Liberty National Life Insurance Company, McKinney, Texas (hereinafter referred to as "Liberty National Life").

Each employee will authorize payroll deduction in a manner agreeable to the Employer and Liberty National Life. An employee may stop payroll deduction by providing appropriate notice to the Employer and Liberty National Life.

Deductions on a schedule to be agreed upon by Liberty National Life and the Employer will be made from salary paid to employees and such deductions will be paid promptly by the Employer to Liberty National Life.

The Employer assumes no responsibility for payroll deduction after the termination of employment of an insured employee, or after an employee stops payroll deduction by providing appropriate notice.

The Employer agrees to continue deductions and remit all premiums as long as the employee agrees to pay for their coverage. Either the Employer or Liberty National Life may terminate this Agreement as of any date by giving at least 30 days written notice to the other prior to such date. After termination of this Agreement, the payment of premiums shall be entirely and directly between each employee and Liberty National Life.

Signature of Employer:

Date: _____

By: _____
Title: _____

Signatures of Affiliated Employers:
By: _____
Title: _____

By: _____
Title: _____

AO #: _____

Agency: _____

Agent Name: _____

Signature of Agent:
_____

Signature of Agency Director:
_____

Signature of Agency Owner:
_____

LIBERTY NATIONAL LIFE INSURANCE COMPANY
APPLICATION FOR GROUP TERM LIFE

Administrative Office:

P.O. Box 8080
McKinney, Texas 75070

1. a. Group Policy Number: LNGE0

b. Holder: _____

2. Group Effective Date: Date of first premium deduction

3. Eligible Person: Current employees, retired employees, former employees and directors of the Holder, and their dependents

_____ _____
Authorized Signature for the Policy Holder | Date

_____ _____ _____
Agent Signature | AO# | Agency
(Not required for 5 digit AOs)

The signing of this application by the Policy Holder (employer) does not constitute an endorsement of Liberty National Life Insurance Company or the Group Term Life Insurance product.

Typed employee list with hire dates must be signed by the employer/payroll administrator. List only those employees who work 28 or more hours per week.

XYZ BUSINESS

1234 STREET AVE, SUITE 321
DALLAS, TX 75000
p: 123.555.1234 f: 123.555.2345
www.xyzbusiness.com

Below is a complete list of XYZ Business employees and their hire dates:

Adams, Chris	February 12, 1992
Douglas, Marsha	September 2, 2000
Dugan, Janelle	March 17, 2002
Evans, Dan	August 28, 1999
Frank, Jim	January 15, 1997
Gregory, Nancy	March 22, 2000
Hudson, Mary	November 5, 2006
Jackson, Sam	October 2, 2003
Jones, Mark	July 21, 2001
Lawton, Judy	April 3, 2009
Michaels, Eric	December 11, 2004
Peterson, Tom	March 21, 2009
Smith, Jay	June 10, 2005
Wilson, Wendy	May 4, 2007

Jane Smith

Employer/Payroll Administrator Signature