Lincoln Financial Group®

Group Information Form

Legal Name of Group: _____

1. Group Contact Information

Who is the Main Contact for Policy and Compliance Administration?

Name: _____ Phone: _____ Email: _____

Who is the Billing Contact?

☐ Same as Main Contact.

If Different,

Name: _____ Phone: _____ Email: _____

Who is the Claims Contact?

☐ Same as Billing Contact.

If Different,

Name: _____ Phone: _____ Email: _____

Who is the Primary Benefit Administrator for the website?

Note: This person will be someone with the group in charge of the web account and must delegate access to other users including the broker.

(Last 5 of contacts SSN is required to initiate/setup online registration access.)

☐ Same as main contact. Please provide last 5 of SSN for Online Access: _____

☐ Different than main contact. Please provide last 5 of SSN for Online Access: _____

Name: _____ Phone: _____ Email: _____

Who is the TravelConnect Contact?

Note: This is only for Life and/or AD&D cases (not valid in NY or WA) that has the TravelConnect value add embedded in the Life and/or AD&D policy. The 24/7 employer contact will be responsible for verifying employment and eligibility for the TravelConnect services.

☐ Same as Main Contact.

If Different,

Name: _____ Phone: _____ Email: _____

2. Location of Employees

Statutory Disability

☐ **Yes** ☐ **No** **Do you have any employees <u>working</u> in CA, HI, NJ, NY or RI?**

If yes, how many, in what state, and how many are covered by the state disability plan?

_____

☐ Yes ☐ No For PFML coverage, do you have any employees working in CO, CT, MA, OR, or WA?

If yes, please specify state or PFML plan: _____

If purchasing NYDBL, please answer below questions.

1. Billing mode preference: ☐ Monthly ☐ Quarterly

   Self Billing is standard, please provide:

   Male: Lives: _____ Volume (monthly covered payroll): _____ DBL Premium: _____ PFL Premium: _____

   Female: Lives: _____ Volume (monthly covered payroll): _____ DBL Premium: _____ PFL Premium: _____

2. Do you have any locations located in NY? ☐ Yes ☐ No

   If yes, provide: Name, Physical address and Tax ID *(add more locations to the "Special Instructions" section on the last page)*.

   Name: _____ Physical Address: _____

   Tax ID: _____

3. Will employees be contributing to the plan? ☐ Yes ☐ No

   Please note, if contributory, Article 9 of New York Workers' Compensation Board regulations limits an employee's contribution to no more than one-half of 1% of the first $120 of weekly statutory disability wages, up to $0.60 per week.

International Employees

☐ Yes ☐ No Do you have any employees working or living outside the United States?

If yes, how many, where and what is the expected return date?

_____

3. Dental Coverage

☐ Yes ☐ No Are you purchasing Dental?

If yes, which Dental plan type(s)? Select from below and complete section information.

☐ **Dental PPO**

If purchasing Dental Coverage, e-delivery is our standard offering for dental ID cards. ID cards are accessed via our portal and dental mobile app by the members.

☐ Enrollment census includes the participating member's email address.
Members will participate in our e-delivery method for accessing dental ID cards. Post onboarding each member will receive an email with instructions on how to access their cards via our portal and dental mobile app.

☐ **Dental Self-Funded**

Members will receive dental ID cards by: ☐ Paper ☐ E-Delivery

☐ **DHMO**

Note: DHMO members will receive paper dental ID cards.

Are Primary Care Physicians (PCPs) included in the census file (CA/TX only)? ☐ Yes ☐ No

If no, PCPs will be auto-assigned, and members may be delayed in visiting a provider.

New Mexico

☐ **Yes** ☐ **No** **Do you have employees living in New Mexico electing Dental Coverage?**

Please note: Effective for policies issued on or after January 1, 2022, New Mexico requires specific fully-insured Dental benefits for employees residing in New Mexico regardless of the employer's residing state. New Mexico employees will be provided these benefits in a different class or plan at the time of sold case and/or at the time of enrollment into Dental coverage.

4. Subsidiaries/Divisions

Does your company have any Divisions (separate locations with the same Employer Identification Number/EIN) or Subsidiaries (locations operating under different EINs)? ☐ Yes ☐ No

Note: Subsidiaries will be included as participating employers in your contract.

☐ Divisions ☐ Subsidiaries

If yes, please provide location information: *(add more contacts to the "Special Instructions" section on the last page)*.

Name: _____ Tax ID: _____

Address: _____ City/State/Zip: _____

Phone: _____ Contact Email: _____

☐ **Yes** ☐ **No Will Subsidiaries/Divisions be billed separately?**

If so, please provide a naming convention for each location. If no name is provided, the legal entity name will be utilized.

5. Third Party Administration Billing & EDI

Does your company use an outside vendor to help administer billing or member eligibility?

☐ **Yes – Technology Vendor** ☐ **Yes – TPA / TPB** ☐ **Yes – EDI** ☐ **None**

If you selected Yes above, please provide your technology solutions for the below functions:

- Benefits Administration: _____
- HRIS/Time and Attendance: _____
- Payroll: _____

☐ No technology solution(s) available

What services do they provide (select all that apply):

☐ Billing
☐ Member Eligibility
☐ EDI file feed

If you are using a vendor, please provide the following:

Platform/Vendor Name: _____

Address: _____ City/State/Zip: _____

Contact Name: _____ Phone Number: _____

Email: _____

Were you sending eligibility files with your prior carrier?

☐ Yes Change-only file
☐ Yes Claims-only file
☐ Yes Full eligibility maintenance file
☐ No Eligibility files

6. Billing Administration

E-Billing is a standard offering. E-Consent form required for this option. Invoice notifications are provided electronically to the billing contact identified in Question 1.

☐ If a paper bill is required, please provide mailing address for invoices:

Address: _____ City/State/Zip: _____

Please select your billing option (Please select one):

☐ List-Billing: Lincoln will provide an invoice for each billing period showing all members and applicable premiums by line of coverage

Structure of List-Bill Invoices (Please select one):

- ☐ One bill, with members listed alphabetically from A-Z.
- ☐ Please provide separate invoices by location/line of coverage *(add details to the "Special Instructions" section on the last page)*
- ☐ Please sort my bill by sub-groups *(add details to the "Special Instructions" section on the last page)*

☐ Self-Billing: Your company will handle employee administration and send Lincoln Financial Group (Lincoln) the total number of lives, volume and premium by line of coverage on a monthly basis.

(NOTE: Periodically, a back-up census will be requested)

How would you like to handle Premium changes for coverages with age banded rates?

☐ Policy Anniversary (standard) ☐ Birthday month

7. ERISA

Does your company have an ERISA Plan Number filed with the Department of Labor?

☐ Yes _____

☐ No

Plan Administrator Name (if different than the group): _____

Plan Year End Date: _____/_____/_____

Plan Number/SPD Number: ☐ Life _____ ☐ STD_____ ☐ LTD _____ ☐ Dental _____
☐ Vision _____ ☐ Vol Life _____ ☐ Vol STD_____ ☐ Vol LTD _____
☐ Accident _____ ☐ Critical Illness _____ ☐ Hospital Indemnity _____

8. Eligibility Information

Initial Enrollment Eligibility and Submission

Number of eligible Employees? _____

How are we enrolling? ☐ Census ☐ Enrollment Forms ☐ Both

When does enrollment end? _____

When are we to expect completed enrollment elections? _____

Minimum Hours - State restrictions may apply

How many hours per week do Full-Time employees need to work to be eligible for coverage?

☐ 30 hours per week

☐ _____ hours per week. If no hours inserted, 30 Hours per week will be utilized.

☐ Varies by class *(add details to the "Special Instructions" section on the last page)*

☐ **Yes** ☐ **No** Are Part-Time Employees included (working under the minimum hours addressed above) who will be eligible for these benefits?

If yes, provide minimum hours: _____

Employee Waiting Period - State restrictions may apply

When will New Hires be eligible for coverage?

☐ Date of Hire (0 day waiting period) ☐ _____ Days ☐ _____ Months ☐ _____ Years

☐ Other: _____

Employee Effective Date - State restrictions may apply

After the waiting period is satisfied, when will employees be effective?

☐ Not applicable – employee is effective on date of hire.

☐ The day following completion of the waiting period.

☐ First of the month following completion of the waiting period. *(NOTE: If the end of the waiting period lands on the first day of the month, Employee will be effective the first day of the next month)*

☐ First of the month following or coinciding completion of the waiting period. *(NOTE: If the end of the waiting period lands on the first day of the month, Employee will be effective that same day)*

☐ Other: _____

☐ **Yes** ☐ **No Do you have any current employees who are still in the above waiting period?**

If yes, when are these employees eligible for coverage?

☐ Policy Effective Date ☐ After completion of the new hire waiting period

(NOTE: Employees who have already satisfied the waiting period will be effective immediately)

When Part-Time Employees move to Full-Time status:

☐ **Yes** ☐ **No Do you have Part-Time employees who become Full-Time employees?**

If yes, please answer the following questions.

☐ Will the new hire waiting period apply from the Full-Time Hire Date or give credit for the Part-Time Hire date?

☐ From the Full-Time Hire Date ☐ Credit for Part-Time Hire Date

Dependent Definition – For coverages with Dependent benefits, do the following apply?

☐ Yes

- ☐ Domestic Partners - The contract should cover Domestic partners as well as spouses (state restrictions may apply).
- ☐ Civil Union- The contract should cover a Civil Union as well as partners (state restrictions may apply).
- ☐ PPACA (Patient Protection and Affordable Care Act) - Dependent Child/Full-Time Student eligible for coverage. Maximum age range 26-30 (state variations may apply).

☐ No

Rehire Provision (following a layoff or termination) - State restrictions may apply

☐ Date of return if rehired within the first 12 months after termination date.

☐ After completing the new hire waiting period, as indicated in Section 8 above.

☐ Other – Please explain in the Special Instructions section on last page.

(NOTE: Benefits for employees returning to work within 6 months of Leave of Absence will be effective on the date of return)

9. Definition of Earnings

Please check all that apply. If selecting Prior Year W2's, then choose tax year or calendar year (earnings are determined on last day worked).

☐ Base pay ☐ Commissions (averaged over 12 months) ☐ Commissions (averaged over 24 months)

☐ Overtime ☐ Bonus (averaged over 12 months) ☐ Prior tax year W2's ☐ Prior calendar year W2's

Do you have any salary-based benefits calculated using K-1 Earnings, in addition to base salary? Indicates those who are receiving income other than their base salary, ex: profits, stocks and/or losses and dividends of a partnership.

☐ Yes ☐ No

If yes

1. Are the earnings ☐ Active (Subject to Social Security taxes, or ☐ Passive (not subject to FICA taxes)
2. Should we use Prior Tax Year or Prior Calendar Year K-1 earning?
   - ☐ Prior tax year K-1 earnings
   - ☐ Prior calendar year K-1 earnings
3. K-1 Earners should be indicated on the census file, How many are included? _____

10. Funding

☐ Yes ☐ No Does your group have a Section 125/Cafeteria Plan?

If Yes, does Employee premium comes from the section 125/Cafeteria Plan?

Check applicable coverages: ☐ Dental ☐ Vision

11. Taxability for Disability Benefits

Do you want Lincoln to pay for Employer's portion of FICA Taxes?

Applies to Short Term Disability (with any level of employer contributions) and NY DBL Coverage.

☐ **Short Term Disability**	☐ **NY DBL**

☐ *Yes - Lincoln will pay the Employer's portion of FICA taxes. In addition, Lincoln will automatically print and mail the W2's to the Employee.*

Note: Additional rates apply for FICA match service and will require an updated proposal if not originally requested.

☐ *No - Lincoln will provide monthly FICA reports. Your company will pay the Employer's portion of FICA taxes.*

If "No", please select ONE of these options:

☐ *W2's are not needed - Employer plans to add STD payments to the Employee's regular wage W2.*

☐ *Courtesy W2 Print Service - Lincoln will print and mail the W2 paperwork to the Employer in January of each year (this will have the Employer's company name and EIN). Employer is responsible for reviewing the paperwork for accuracy, distributing W2's to Employees, and reporting W2's to the government.*

☐ *STD Non-Taxable W2 Service - Lincoln will distribute IRS Form W2 directly to the employee's home. The W2 will be generated under Lincoln's name and EIN. Lincoln will also provide Annual FICA reports to the Employer as well as Monthly Claim Status and Explanation of Benefits Reports to the Employer each month in which a claim is paid.*

Note: FICA match and W2 Reporting are automatically included for Long Term Disability at no additional charge.

For contributory Short Term and Long Term Disability benefits, the Employee's premium is funded from:

☐ Pre-Tax Payroll Deductions: Employees will receive the benefit after taxes (Lincoln will withhold taxes).

☐ Post-Tax Payroll Deductions: Employees will receive the benefit with no taxes taken out.

☐ Tax Choice: Each employee can choose the method of contribution.

If you had prior coverage with another carrier, please provide all contracts or certificates and most recent bill.

Completed By:

_____ _____

Broker or Client Name (Please print) Date

Special Instructions (please use additional space, if needed):