

New Group Approval Request



Fax and mail original signed/completed Form to:
 Sterling Benefit Solutions
 Attn: Account Manager
 PO Box 26103
 Overland Park, KS 66225

Contact Customer Service with requests/questions: 877.205.2069
 FAX #: 913.498.9096
 Or email requests/questions to: benefits@americansterling.com

All underwriting requirements MUST be received no later than the 1st of the month preceding the requested effective date

Group Name	
Billing Information	(ONLY if different than Employer Application)
Address	
City/State/Zip	
Contact Person Title	
Phone	
Fax	
Email	
Definition of eligibility	
# of Full time employees	
# of Part time employees	
Approx new hires per year	
Locations	
States of locations	
Pay periods	Monthly Semi-Monthly Bi-Weekly Weekly Other
Payroll deductions	12 24 26 52 _____ Other
Billing Method	List Bill _____ Special Bill Request _____ (Requires prior approval)
Process of enrollment	One-on-One _____ Group Meetings _____ Self Enroll _____ Other _____
# Open enrollment materials required	
# New hire enrollment materials required	
Mailing address for enrollment materials	
Special requests/notes:	

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Rates	Limited Medical Indemnity Plan
\$	Employee only
\$	Employee + Spouse
\$	Employee + Child(ren)
\$	Family
	Optional RX
\$	Employee only
\$	Employee + Spouse
\$	Employee + Child(ren)
\$	Family
	Optional Life & AD&D
\$	Employee only
\$	Employee + Spouse
\$	Employee + Child(ren)
\$	Family
	Optional STD
\$	Employee only
\$	Employee + Spouse
\$	Employee + Child(ren)
\$	Family
	Optional Dental
\$	Employee only
\$	Employee + Spouse
\$	Employee + Child(ren)
\$	Family
	Optional Vision
\$	Employee only
\$	Employee + Spouse
\$	Employee + Child(ren)
\$	Family

Required Authorization

Signing below acknowledges the above information is complete, correct and final. Any changes will require additional signed authorization by the parties listed below. Sterling Benefit Solutions is given authorization to use this information to establish custom enrollment forms and administrative materials.

Agent Name	Agent Signature
Co-Agent Name	Co-Agent Signature
Authorized Group Representative Name/Title	Authorized Group Representative Signature
ASIS Manager Name	ASIS Manager Signature

Coverage not in effect until submitted and approved by FSL

Approved by: _____ Please print Name: _____	Yes _____ No _____
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