PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

List Bill Procedure

PAL UNIVERSITY

Group Business Underwriting Guide Updates

Starting **April 1, 2022**, the following underwriting updates will apply.

All New Group Business:

- Critical Illness benefits of $40,000 or more will require a telephone interview

New <u>Guarantee Issue</u> Group Business:

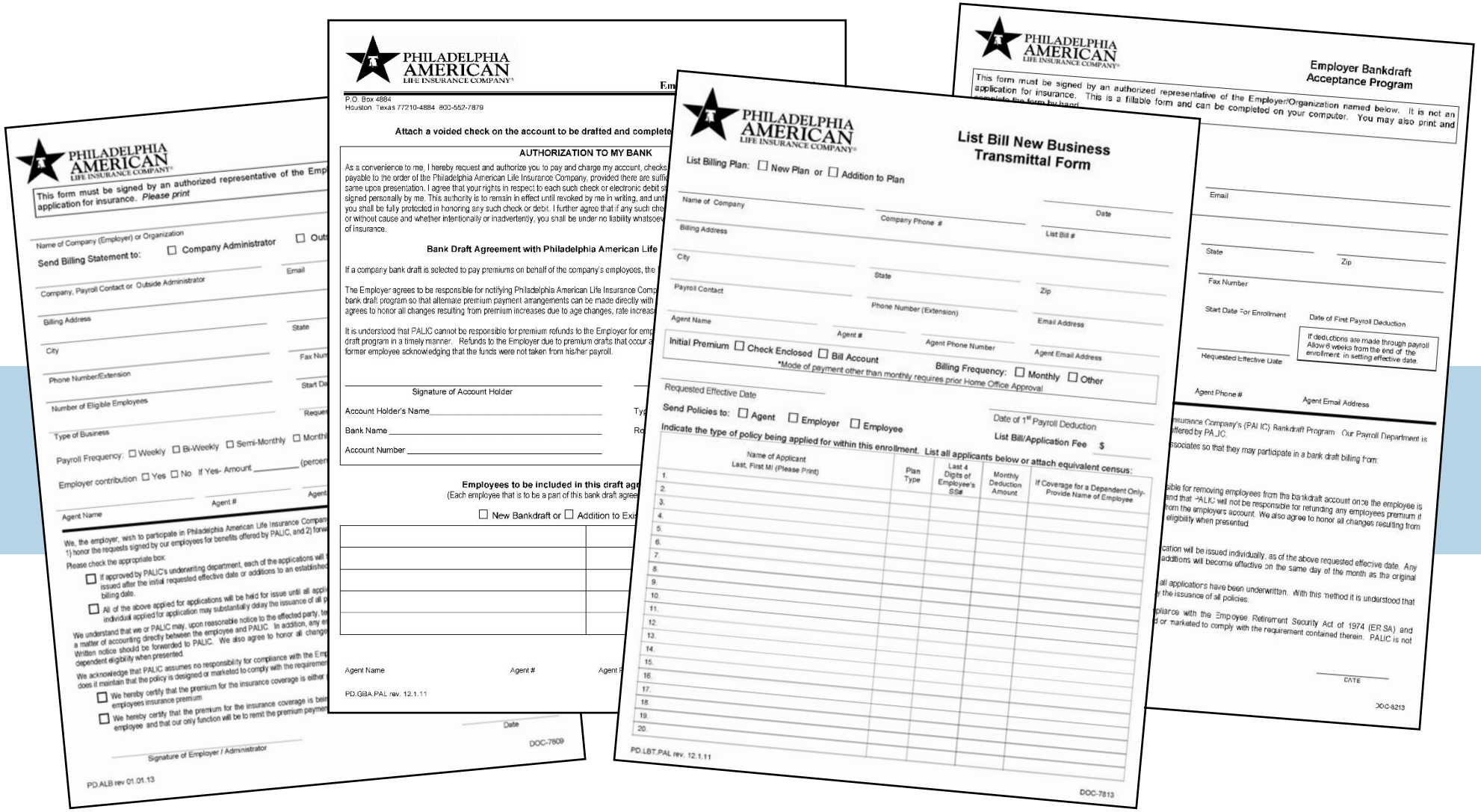
- When writing GI groups, only submit employees that are to be GI based on the participation rules
- 15% rate-up on total HSP or HCS Series premium of all employees will apply
- GI is only available to employees who are included in the initial enrollment; after initial enrollment, any employees added must complete a separate application and answer all medical questions; approval will be subject to the current underwriting rules
- HSP or HCS Series GI policies can be written for employees only
- Any dependents of the employee wanting coverage must complete a separate application and answer all medical questions
- All employee coverage for GI HSP or HCS Series policies must have the same deductible, calendar year maximum, and units
- For GI HSP policies, One Unit plans must have a deductible no lower than $2,500 and Two Unit plans must have a deductible no lower than $5,000
- Employees wanting to purchase additional supplemental coverage must submit a separate application and answer all medical questions; a 15% rate-up will apply

3 Easy Steps Setting Up a List Bill

1. Determine how many employees will apply for coverage.
2. Payment Mode: Employer Bank Draft or Standard (mail payment)
3. Submit ALL forms required to receive a GBN Number.

Bank Draft	Standard List Bill (mail payment)
1. Maximum of 12 Employees 2. Forms Required - Acceptance Form Doc-7810 - Bank Auth. Form Doc-7812 3. Include a VOIDED Check	1. No Limit 2. Forms Required - Acceptance Form Doc-9773 - Transmittal Form Doc-7813/8213 3. Mail Application Fee Check for $150

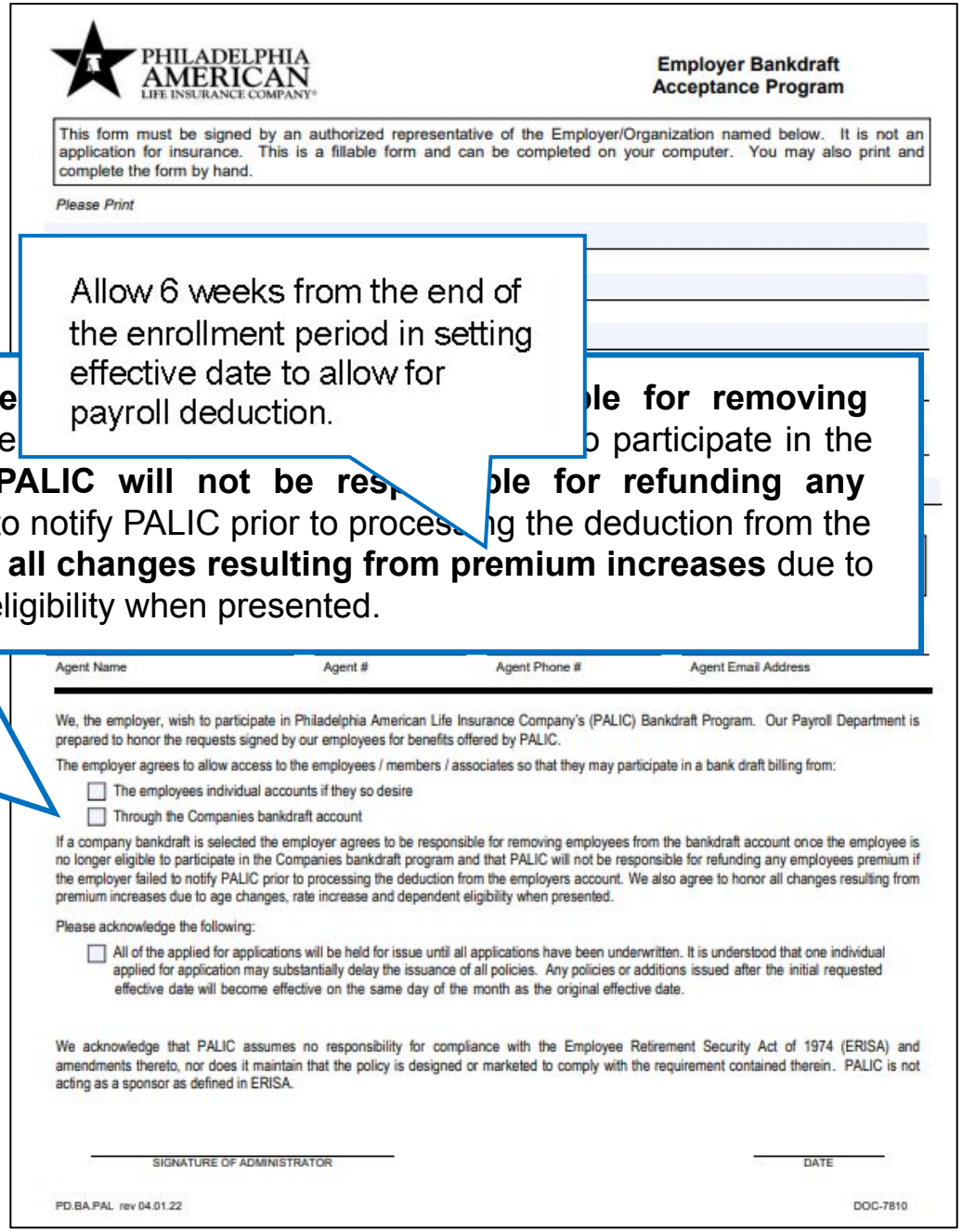
Easy To Use Forms



Employers Bankdraft Acceptance Program

Allow 6 weeks from the end of the enrollment period in setting effective date to allow for payroll deduction.

If a company bankdraft is selected the e**ble for removing employees** from the bankdraft account once o participate in the Companies bankdraft program and that **PALIC will not be resp ble for refunding any employees premium** if the employer failed to notify PALIC prior to proces g the deduction from the employers account. We also agree to **honor all changes resulting from premium increases** due to age changes, rate increase and dependent eligibility when presented.



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Employer Bankdraft Acceptance Program

This form must be signed by an authorized representative of the Employer/Organization named below. It is not an application for insurance. This is a fillable form and can be completed on your computer. You may also print and complete the form by hand.

Please Print

Agent Name | Agent # | Agent Phone # | Agent Email Address

We, the employer, wish to participate in Philadelphia American Life Insurance Company's (PALIC) Bankdraft Program. Our Payroll Department is prepared to honor the requests signed by our employees for benefits offered by PALIC.

The employer agrees to allow access to the employees / members / associates so that they may participate in a bank draft billing from:

- ☐ The employees individual accounts if they so desire
- ☐ Through the Companies bankdraft account

If a company bankdraft is selected the employer agrees to be responsible for removing employees from the bankdraft account once the employee is no longer eligible to participate in the Companies bankdraft program and that PALIC will not be responsible for refunding any employees premium if the employer failed to notify PALIC prior to processing the deduction from the employers account. We also agree to honor all changes resulting from premium increases due to age changes, rate increase and dependent eligibility when presented.

Please acknowledge the following:

- ☐ All of the applied for applications will be held for issue until all applications have been underwritten. It is understood that one individual applied for application may substantially delay the issuance of all policies. Any policies or additions issued after the initial requested effective date will become effective on the same day of the month as the original effective date.

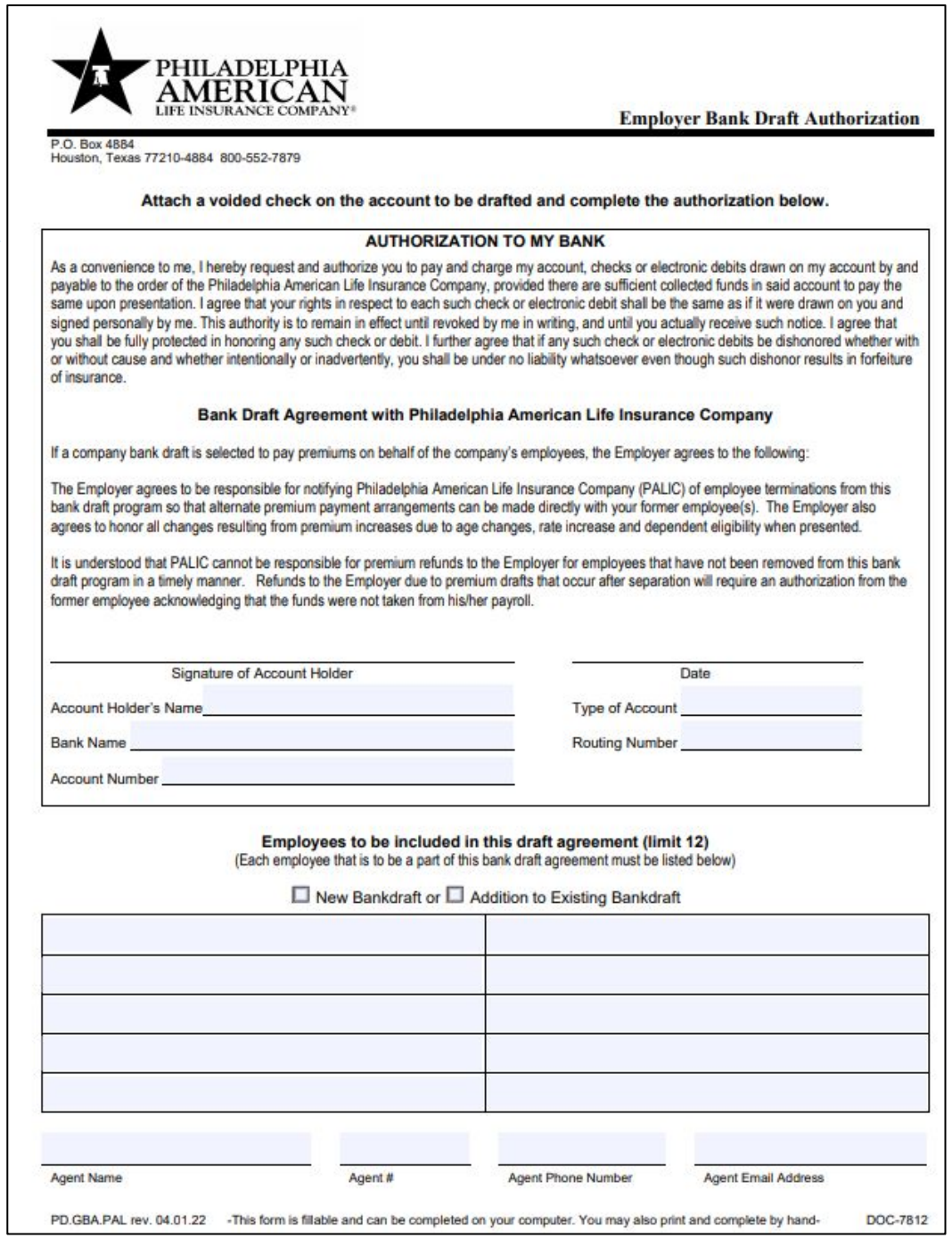
We acknowledge that PALIC assumes no responsibility for compliance with the Employee Retirement Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirement contained therein. PALIC is not acting as a sponsor as defined in ERISA.

SIGNATURE OF ADMINISTRATOR | DATE

PD.BA.PAL rev 04.01.22 | DOC-7810

DOC-7810

1. Attach a voided check on the account to be drafted and complete the authorization below
2. Include List Bill / Application Fee $ 150 ($30 per HSP/HCS with a $150 max) per employer)
3. If Contingent Issue is requested complete this section on the form and have the form signed by the company administrator



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

Employer Bank Draft Authorization

P.O. Box 4884
Houston, Texas 77210-4884 800-552-7879

Attach a voided check on the account to be drafted and complete the authorization below.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks or electronic debits drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check or debit. I further agree that if any such check or electronic debits be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Bank Draft Agreement with Philadelphia American Life Insurance Company

If a company bank draft is selected to pay premiums on behalf of the company's employees, the Employer agrees to the following:

The Employer agrees to be responsible for notifying Philadelphia American Life Insurance Company (PALIC) of employee terminations from this bank draft program so that alternate premium payment arrangements can be made directly with your former employee(s). The Employer also agrees to honor all changes resulting from premium increases due to age changes, rate increase and dependent eligibility when presented.

It is understood that PALIC cannot be responsible for premium refunds to the Employer for employees that have not been removed from this bank draft program in a timely manner. Refunds to the Employer due to premium drafts that occur after separation will require an authorization from the former employee acknowledging that the funds were not taken from his/her payroll.

Signature of Account Holder _____ Date _____

Account Holder's Name _____ Type of Account _____

Bank Name _____ Routing Number _____

Account Number _____

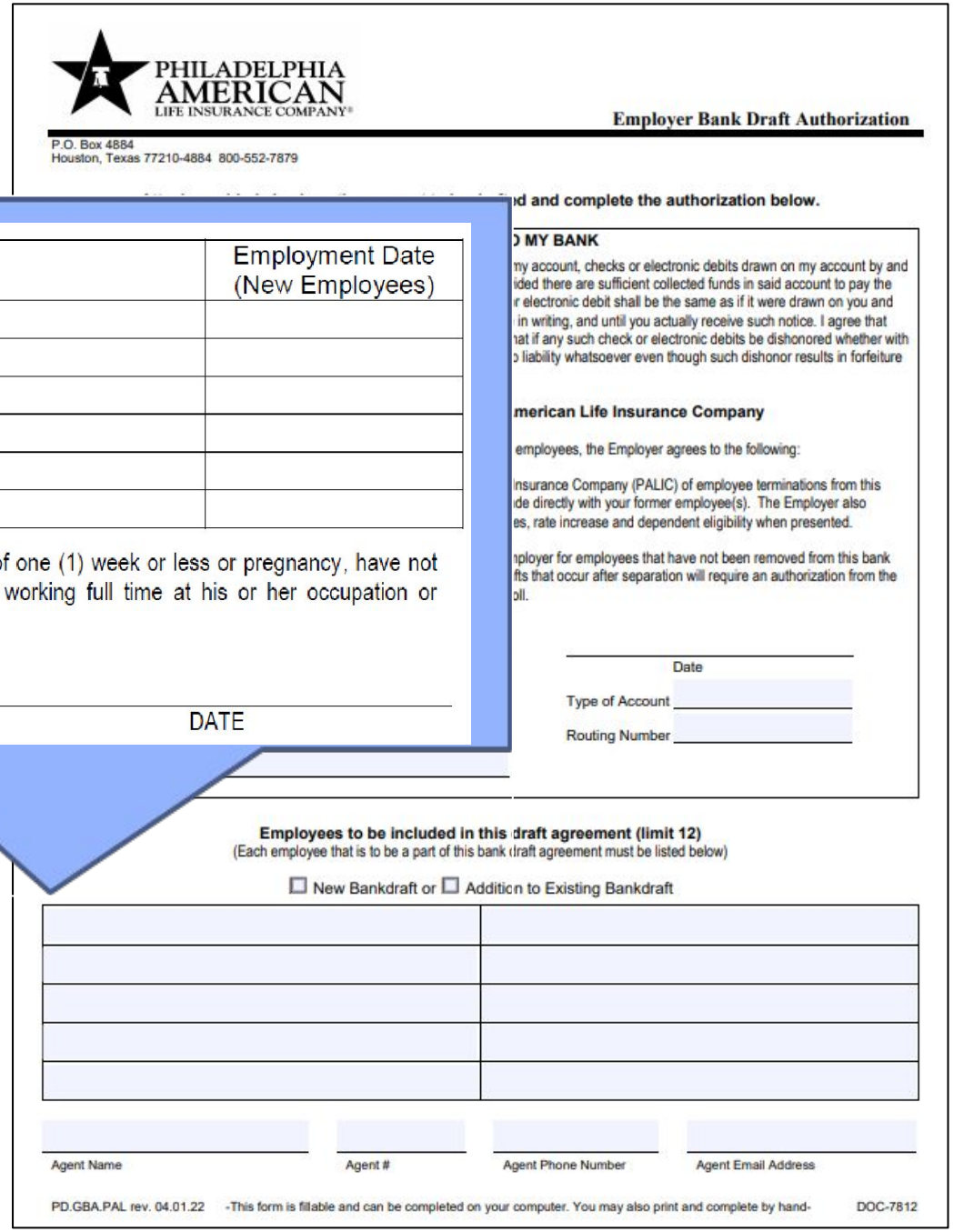
Employees to be included in this draft agreement (limit 12)
(Each employee that is to be a part of this bank draft agreement must be listed below)

☐ New Bankdraft or ☐ Addition to Existing Bankdraft

Agent Name _____ Agent # _____ Agent Phone Number _____ Agent Email Address _____

PD.GBA.PAL rev. 04.01.22 -This form is fillable and can be completed on your computer. You may also print and complete by hand- DOC-7812

DOC-7812



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 4884
Houston, Texas 77210-4884 800-552-7879

Employer Bank Draft Authorization

d and complete the authorization below.

MY BANK

my account, checks or electronic debits drawn on my account by and ided there are sufficient collected funds in said account to pay the r electronic debit shall be the same as if it were drawn on you and in writing, and until you actually receive such notice. I agree that at if any such check or electronic debits be dishonored whether with liability whatsoever even though such dishonor results in forfeiture

merican Life Insurance Company

employees, the Employer agrees to the following:

nsurance Company (PALIC) of employee terminations from this de directly with your former employee(s). The Employer also es, rate increase and dependent eligibility when presented.

nployer for employees that have not been removed from this bank fts that occur after separation will require an authorization from the oll.

Date

Type of Account

Routing Number

Employees to be included in this draft agreement (limit 12)
(Each employee that is to be a part of this bank draft agreement must be listed below)

☐ New Bankdraft or ☐ Addition to Existing Bankdraft

Agent Name | Agent # | Agent Phone Number | Agent Email Address

PD.GBA.PAL rev. 04.01.22 -This form is fillable and can be completed on your computer. You may also print and complete by hand- DOC-7812

Name of Applicant	Employment Date (New Employees)	Name of Applicant	Employment Date (New Employees)

The employee(s) listed above attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his or her occupation or performing the normal activities of a person of the same age.

SIGNATURE OF ADMINISTRATOR

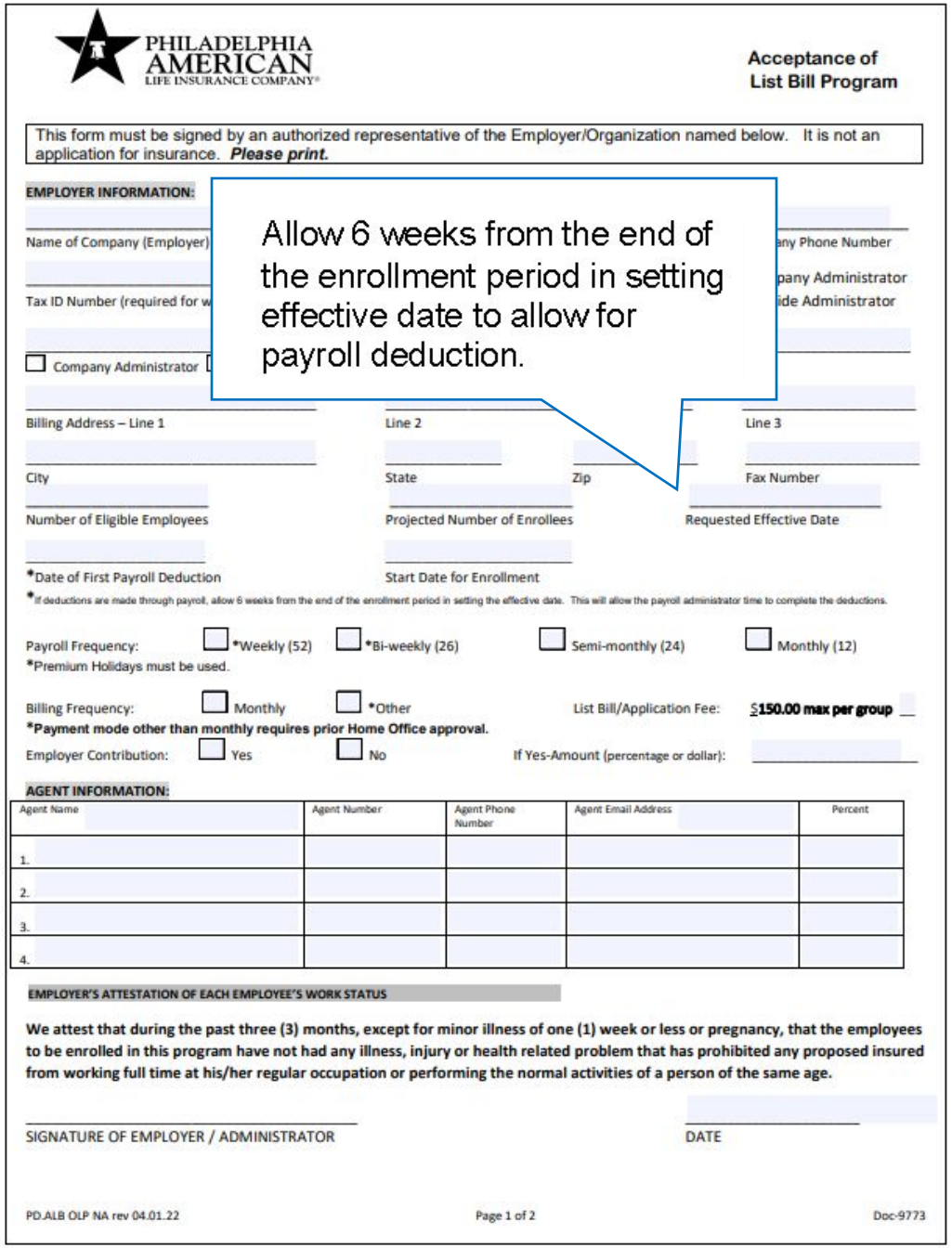
DATE

DOC-7812

Acceptance of List Bill Program

DOC-9773

Page 1 of 2



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

Acceptance of List Bill Program

This form must be signed by an authorized representative of the Employer/Organization named below. It is not an application for insurance. ***Please print.***

EMPLOYER INFORMATION:

Name of Company (Employer)

Tax ID Number (required for w

Company Administrator

Billing Address – Line 1 | Line 2 | Line 3

City | State | Zip | Fax Number

Number of Eligible Employees | Projected Number of Enrollees | Requested Effective Date

*Date of First Payroll Deduction | Start Date for Enrollment

*If deductions are made through payroll, allow 6 weeks from the end of the enrollment period in setting the effective date. This will allow the payroll administrator time to complete the deductions.

Payroll Frequency: *Weekly (52) *Bi-weekly (26) Semi-monthly (24) Monthly (12)

*Premium Holidays must be used.

Billing Frequency: Monthly *Other List Bill/Application Fee: $150.00 max per group

***Payment mode other than monthly requires prior Home Office approval.**

Employer Contribution: Yes No If Yes-Amount (percentage or dollar):

AGENT INFORMATION:

Agent Name	Agent Number	Agent Phone Number	Agent Email Address	Percent
1.				
2.				
3.				
4.				

EMPLOYER'S ATTESTATION OF EACH EMPLOYEE'S WORK STATUS

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees to be enrolled in this program have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

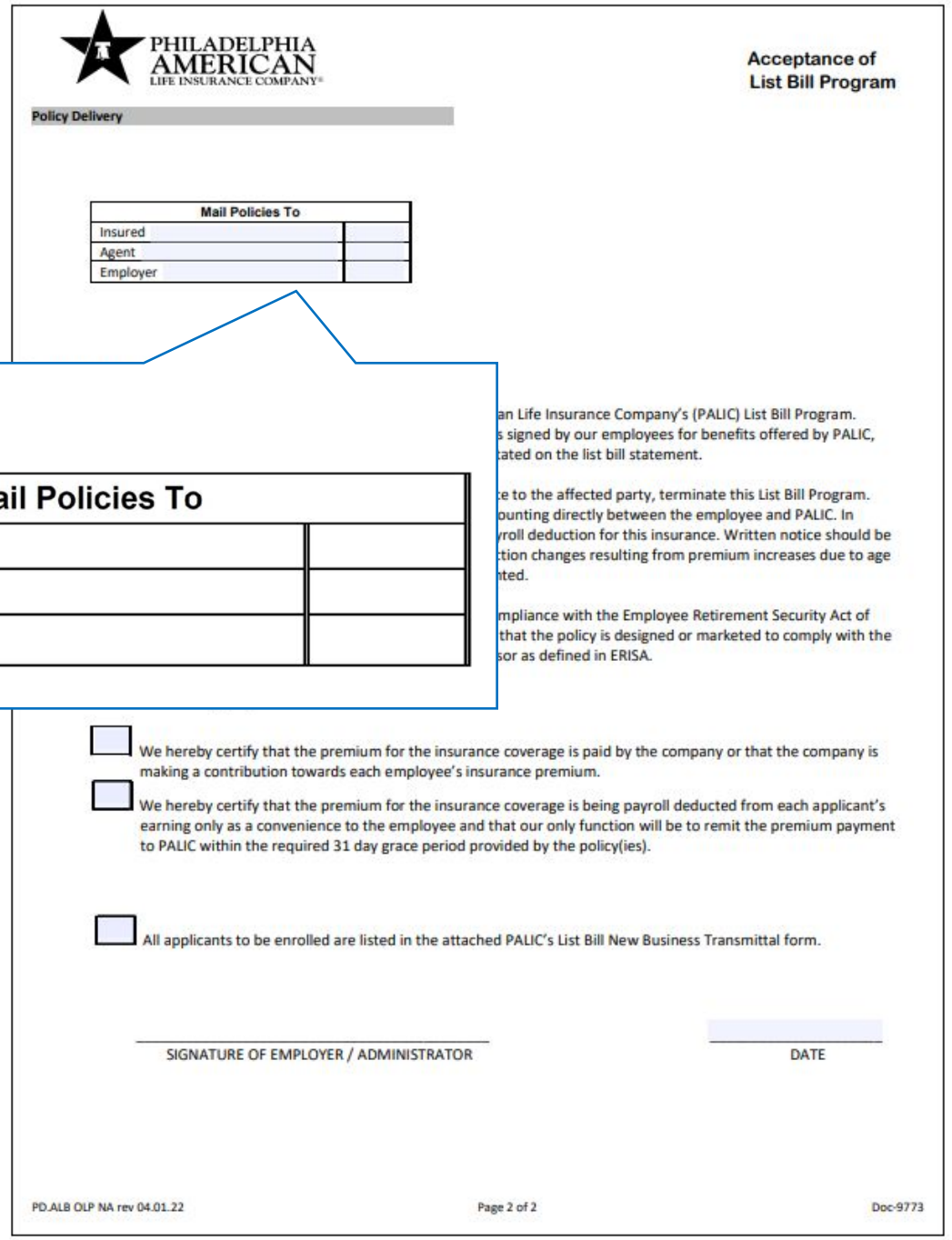
SIGNATURE OF EMPLOYER / ADMINISTRATOR | DATE

PD.ALB OLP NA rev 04.01.22 Page 1 of 2 Doc-9773

Allow 6 weeks from the end of the enrollment period in setting effective date to allow for payroll deduction.

Acceptance of List Bill Program

DOC-9773



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Acceptance of List Bill Program

Policy Delivery

Mail Policies To	
Insured	
Agent	
Employer	

an Life Insurance Company's (PALIC) List Bill Program.
s signed by our employees for benefits offered by PALIC,
tated on the list bill statement.

e to the affected party, terminate this List Bill Program.
bunting directly between the employee and PALIC. In
yroll deduction for this insurance. Written notice should be
tion changes resulting from premium increases due to age
nted.

mpliance with the Employee Retirement Security Act of
that the policy is designed or marketed to comply with the
sor as defined in ERISA.

☐ We hereby certify that the premium for the insurance coverage is paid by the company or that the company is making a contribution towards each employee's insurance premium.

☐ We hereby certify that the premium for the insurance coverage is being payroll deducted from each applicant's earning only as a convenience to the employee and that our only function will be to remit the premium payment to PALIC within the required 31 day grace period provided by the policy(ies).

☐ All applicants to be enrolled are listed in the attached PALIC's List Bill New Business Transmittal form.

SIGNATURE OF EMPLOYER / ADMINISTRATOR

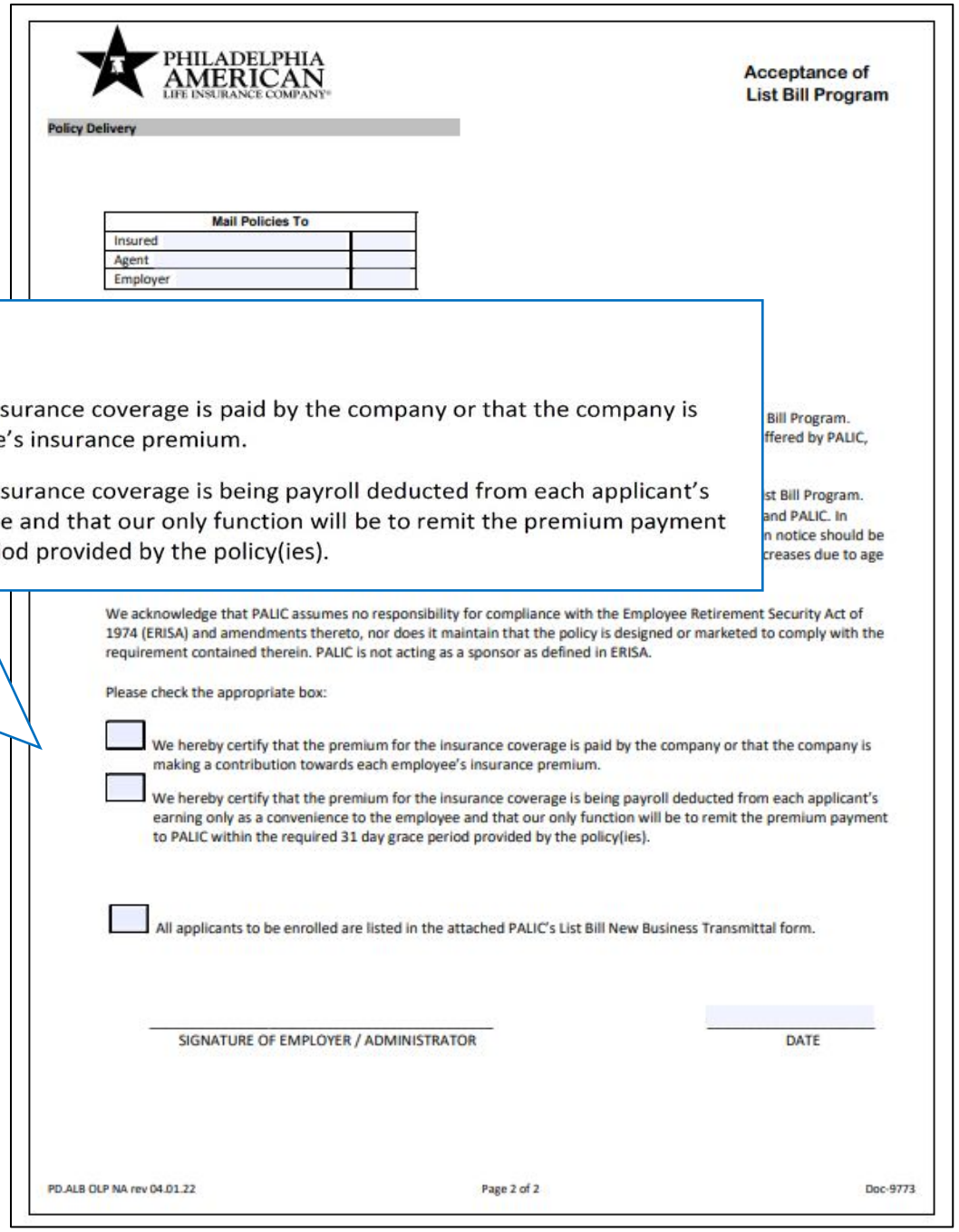
DATE

PD.ALB OLP NA rev 04.01.22 Page 2 of 2 Doc-9773

Policy Delivery

Mail Policies To	
Insured	
Agent	
Employer	

Acceptance of List Bill Program



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

Acceptance of List Bill Program

Policy Delivery

Mail Policies To	
Insured	
Agent	
Employer	

Please check the appropriate box:

☐ We hereby certify that the premium for the insurance coverage is paid by the company or that the company is making a contribution towards each employee's insurance premium.

☐ We hereby certify that the premium for the insurance coverage is being payroll deducted from each applicant's earning only as a convenience to the employee and that our only function will be to remit the premium payment to PALIC within the required 31 day grace period provided by the policy(ies).

Bill Program.
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creases due to age

We acknowledge that PALIC assumes no responsibility for compliance with the Employee Retirement Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirement contained therein. PALIC is not acting as a sponsor as defined in ERISA.

Please check the appropriate box:

☐ We hereby certify that the premium for the insurance coverage is paid by the company or that the company is making a contribution towards each employee's insurance premium.

☐ We hereby certify that the premium for the insurance coverage is being payroll deducted from each applicant's earning only as a convenience to the employee and that our only function will be to remit the premium payment to PALIC within the required 31 day grace period provided by the policy(ies).

☐ All applicants to be enrolled are listed in the attached PALIC's List Bill New Business Transmittal form.

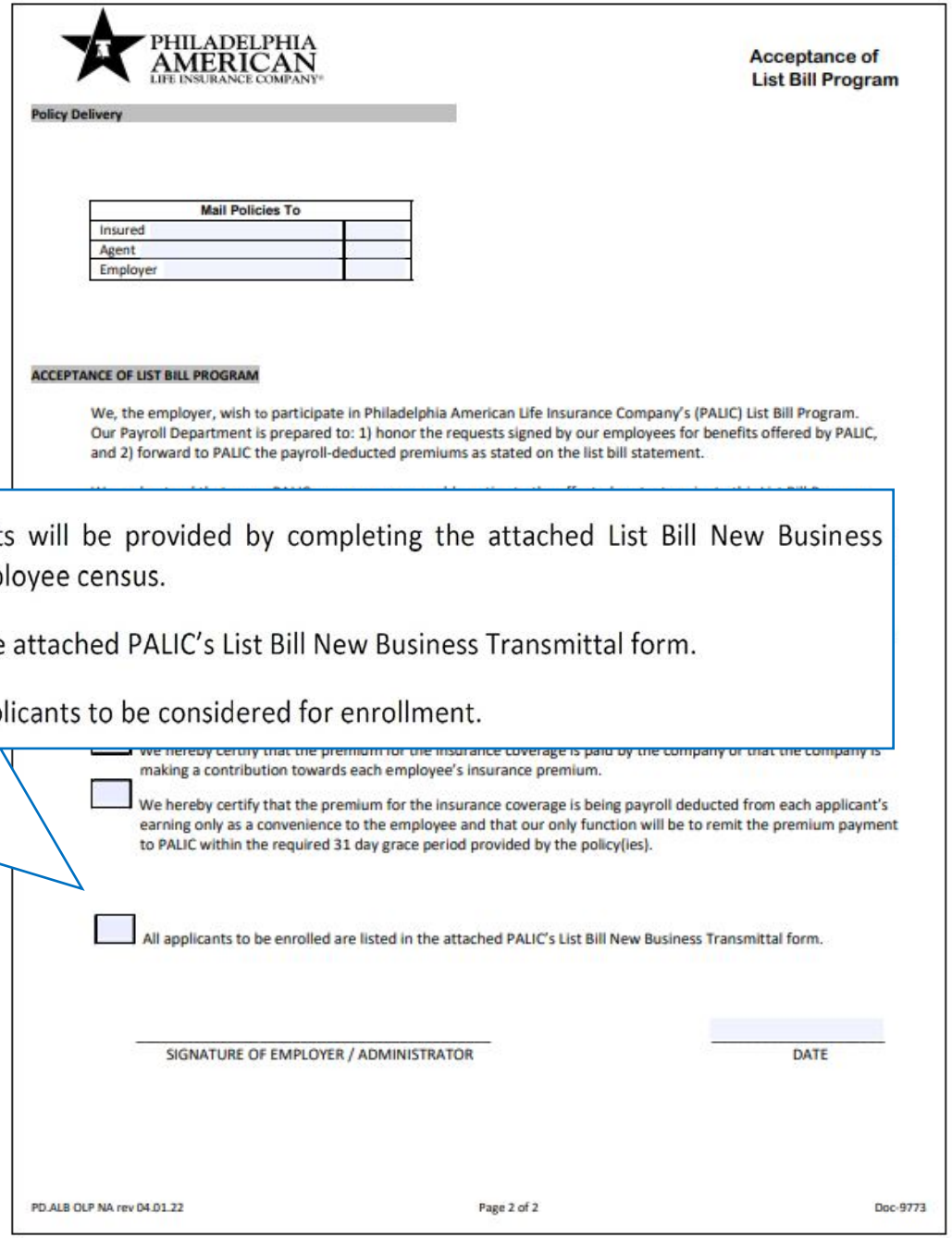
SIGNATURE OF EMPLOYER / ADMINISTRATOR

DATE

PD.ALB OLP NA rev 04.01.22 Page 2 of 2 Doc-9773

DOC-9773

Acceptance of List Bill Program



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Acceptance of List Bill Program

Policy Delivery

Mail Policies To	
Insured	
Agent	
Employer	

ACCEPTANCE OF LIST BILL PROGRAM

We, the employer, wish to participate in Philadelphia American Life Insurance Company's (PALIC) List Bill Program. Our Payroll Department is prepared to: 1) honor the requests signed by our employees for benefits offered by PALIC, and 2) forward to PALIC the payroll-deducted premiums as stated on the list bill statement.

Please indicate below whether a list of applicants will be provided by completing the attached List Bill New Business Transmittal form or by attaching an equivalent employee census.

☐ All applicants to be enrolled are listed in the attached PALIC's List Bill New Business Transmittal form.

☐ Attached is employee census data of all applicants to be considered for enrollment.

making a contribution towards each employee's insurance premium.

☐ We hereby certify that the premium for the insurance coverage is being payroll deducted from each applicant's earning only as a convenience to the employee and that our only function will be to remit the premium payment to PALIC within the required 31 day grace period provided by the policy(ies).

☐ All applicants to be enrolled are listed in the attached PALIC's List Bill New Business Transmittal form.

SIGNATURE OF EMPLOYER / ADMINISTRATOR

DATE

PD.ALB OLP NA rev 04.01.22 Page 2 of 2 Doc-9773

DOC-9773

List Bill New Business Transmittal Form Standard Issue

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

List Bill New Business Transmittal Form

List Billing Plan: ☐ New Plan or ☐ Addition to Plan

Date

Name of Company | Company Phone # | List Bill #

Billing Address

City

Payroll Contact

Agent Name

Initial Premium ☐ Check Enclos

*Mode of payment other than monthly requires prior Home Office Approva

Requested Effective Date

Date of 1st Payroll Ded

Send Policies to: ☐ Agent ☐ Employer ☐ Employee

List Bill/Application Fee $

Indicate the type of policy being applied for within this enrollment. List all applicants below or attach equivalent census:

Name of Applicant Last, First MI (Please Print)	Plan Type	Last 4 Digits of Employee's SS#	Monthly Deduction Amount	If Coverage for a Dependent Only- Provide Name of Employee
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

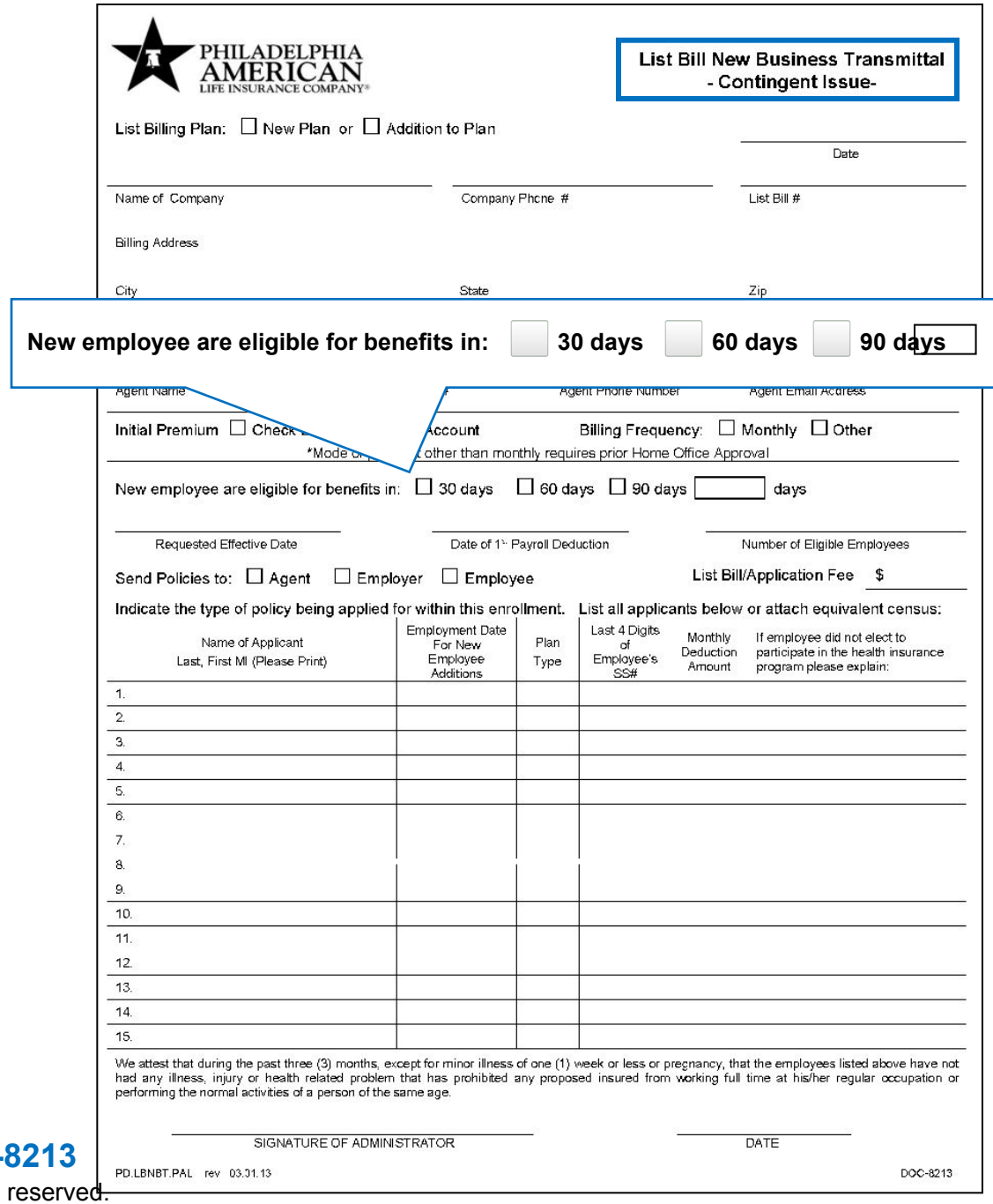
PD.LBT.PAL rev. 12.1.11 DOC-7813

List Bill/Application Fee **$150.00**

$30 Per HSP / HCS Apps with a $150 max per employer.

DOC-7813

List Bill New Business Transmittal Form Contingent Issue



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

List Bill New Business Transmittal - Contingent Issue-

List Billing Plan: ☐ New Plan or ☐ Addition to Plan

Date

Name of Company | Company Phone # | List Bill #

Billing Address

City | State | Zip

New employee are eligible for benefits in: ☐ 30 days ☐ 60 days ☐ 90 days ☐ days

Agent Name | Agent Phone Number | Agent Email Address

Initial Premium ☐ Check ☐ Account Billing Frequency: ☐ Monthly ☐ Other

*Mode other than monthly requires prior Home Office Approval

New employee are eligible for benefits in: ☐ 30 days ☐ 60 days ☐ 90 days ☐ days

Requested Effective Date | Date of 1st Payroll Deduction | Number of Eligible Employees

Send Policies to: ☐ Agent ☐ Employer ☐ Employee List Bill/Application Fee $

Indicate the type of policy being applied for within this enrollment. List all applicants below or attach equivalent census:

	Name of Applicant Last, First MI (Please Print)	Employment Date For New Employee Additions	Plan Type	Last 4 Digits of Employee's SS#	Monthly Deduction Amount	If employee did not elect to participate in the health insurance program please explain:
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

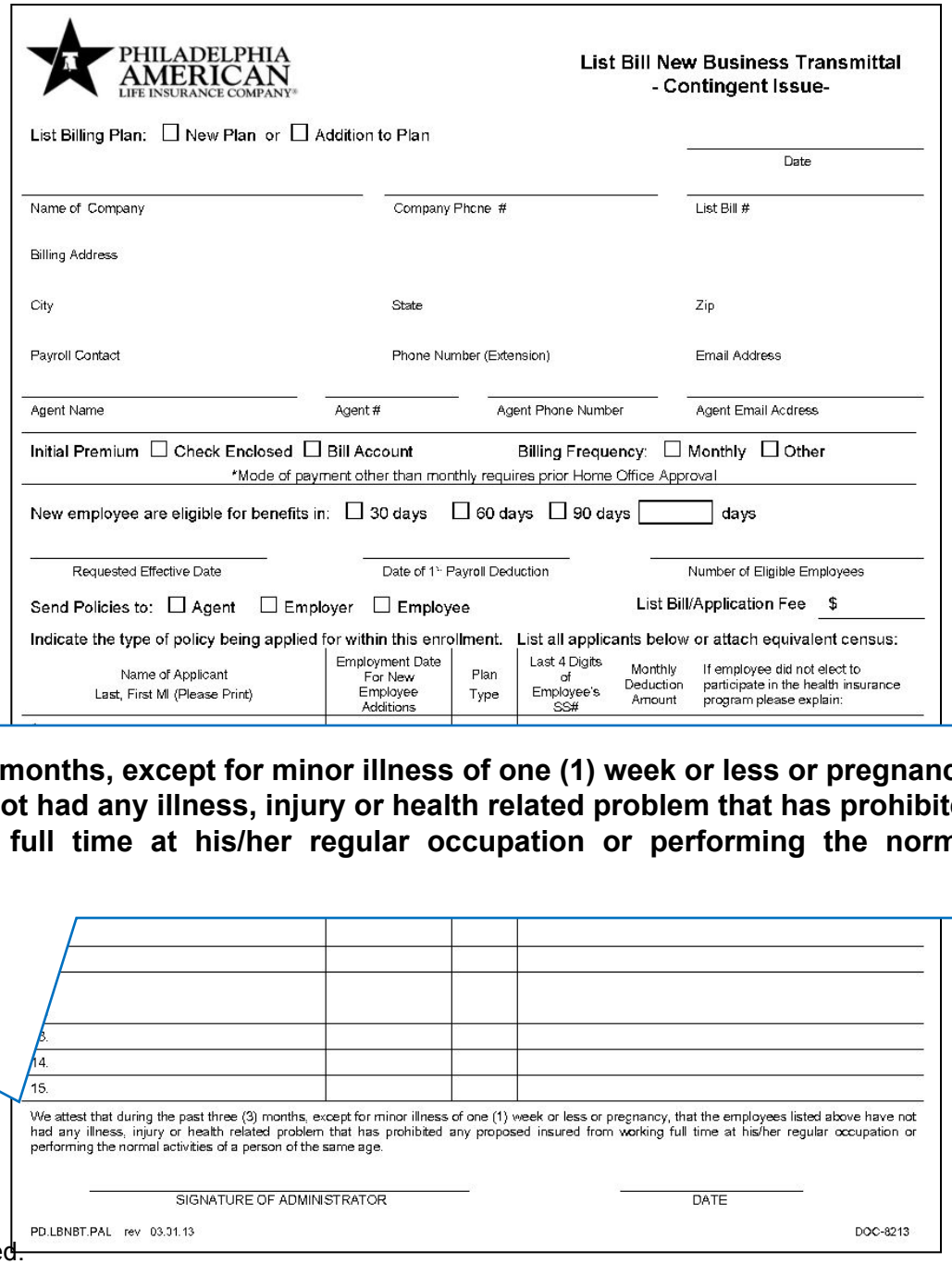
We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees listed above have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

SIGNATURE OF ADMINISTRATOR | DATE

PD.LBNBT.PAL rev 03.01.13 DOC-8213

DOC-8213

List Bill New Business Transmittal Form Contingent Issue



PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

List Bill New Business Transmittal
- Contingent Issue-

List Billing Plan: ☐ New Plan or ☐ Addition to Plan

Date

Name of Company | Company Phone # | List Bill #

Billing Address

City | State | Zip

Payroll Contact | Phone Number (Extension) | Email Address

Agent Name | Agent # | Agent Phone Number | Agent Email Address

Initial Premium ☐ Check Enclosed ☐ Bill Account Billing Frequency: ☐ Monthly ☐ Other

*Mode of payment other than monthly requires prior Home Office Approval

New employee are eligible for benefits in: ☐ 30 days ☐ 60 days ☐ 90 days ☐ days

Requested Effective Date | Date of 1st Payroll Deduction | Number of Eligible Employees

Send Policies to: ☐ Agent ☐ Employer ☐ Employee List Bill/Application Fee $

Indicate the type of policy being applied for within this enrollment. List all applicants below or attach equivalent census:

Name of Applicant Last, First MI (Please Print)	Employment Date For New Employee Additions	Plan Type	Last 4 Digits of Employee's SS#	Monthly Deduction Amount	If employee did not elect to participate in the health insurance program please explain:
13.					
14.					
15.					

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees listed above have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

SIGNATURE OF ADMINISTRATOR | DATE

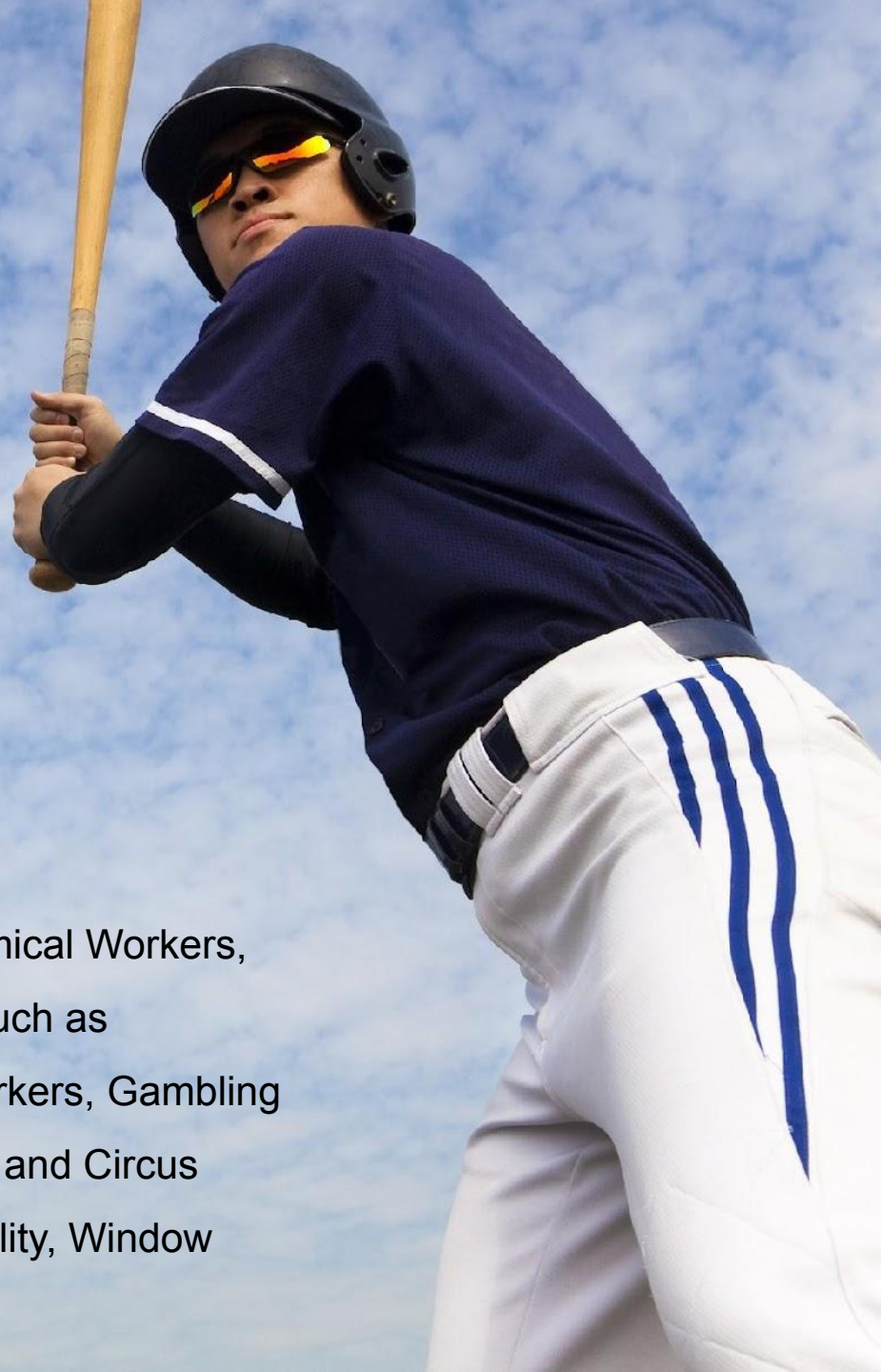
PD.LBNBT.PAL rev 03.01.13 DOC-8213

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees listed above have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

DOC-8213

Rules for Contingent Issue Underwriting

Rules for Contingent Issue Underwriting



Employer Eligibility:

The industry must not be on this list of Ineligible Industries.

Adult Entertainers/Dancers, Armed Services (Active Duty), Asbestos/Toxic Chemical Workers, Athletes-Professional or Semi-Professional (who participate in a contact sport such as (Football, Soccer, Basketball, Baseball, Wrestling), Crop Dusters, Explosive Workers, Gambling and Racing related workers, High Rise Steel workers, Race Car Drivers, Rodeo and Circus worker, skydivers, Stuntmen, Underground Workers, Unemployed due to disability, Window washers above 3 stories

Rules for Contingent Issue Underwriting

Employee Qualification:

- **The health plans are available as long as the employee has not reached age 65.**
- **Employee's must work at least 28 hours weekly to be included in the list bill.**
- **Initial Enrollment Period is the time that an employee is eligible and applying for coverage and last for 31 days.**
    - For employee's to be added after the initial enrollment period, they will be considered a late enrollee and must wait until the waiting period is met. This period is determined by the employer and the employee must apply within 31 days after that time period. Otherwise they will be subject to full underwriting.

Rules for Contingent Issue Underwriting

Dependent Eligibility:

- Spouses-Ages 17-65, Dependent Children Ages 0-25 (This may vary by state)
- Coverage may be applied for when the employee is eligible and applying for coverage in order to qualify for contingent issue. All applicants purchasing Critical Illness will have to answer the questions on the Critical Illness application.
- If an employee marries, adopts a child or is court ordered to cover eligible dependents, those dependents must apply for coverage within 31 days of the time they are eligible. Anyone applying meeting this and wants to purchase Critical Illness must answer all of the questions on the Critical Illness application.

  - Any late enrollee must show evidence of insurability at the expense of the employee

Eligibility Guidelines

# Eligible Employees	Minimum #	HSP Series/ Health Choice Select/Enhanced Accident Plan	Critical Illness/On separate apps	GAP Plan (Cannot be sold with the HSP Series or HCS)
5-9 employees	Full Underwriting	All questions need to be answered and phone interviews are required.	Applicant may apply for up to $40k or $50k of CI benefit and must answer NO to all of the questions and a Phone interview is required.	Maximum Benefit Level $6,000. Must have a Primary Medical Policy in force. Phone or electronic interview is required.
10-15 employees	8 Participating Employees Purchasing HSP Series / HCS/GAP	**Guaranteed Issue** ON THE NEW HSP GOLD PLAN THE LOWEST DEDUCTIBLE ALLOWED FOR THE 1 UNIT PLAN FOR GI IS $2,500 OR $5,000 ON THE 2 UNIT Plan on a GI basis. On the HCS, they are eligible for a 20% first day plan. The EAP can be GI if an HSP Series or HCS is included. No DI or Accident rider allowed on GI basis. No GI on standalone EAP. The Enhanced Benefit rider or the ER/Urgent care rider are available for GI but if offered everyone must have the rider. The CYM of $100,000 or $250,000 are allowed. No questions need to be answered nor E—Verification Needed.	Applicant may apply for up to $40K or $50K of CI benefit and must answer NO to all of the questions. A Phone Interview is required.	**Guaranteed Issue** Maximum Benefit Level $6,000 No Questions will need to be answered. Must have a Primary Medical Policy in force No phone interviews Required **Simplified Issue Only** Up to maximum benefit of $6,000All questions will need to be answered. No phone interviews required

Eligibility Guidelines

16 –24 employees 25-36 employees 37–50 employees	12 Participating Employees Purchasing HSP / HCS/GAP18 Participating Employees Purchasing HSP / HCS/GAP 25 Participating Employees Purchasing HSP / HCS/GAP	**Guaranteed Issue** ON THE NEW HSP GOLD PLAN THE LOWEST DEDUCTIBLE ALLOWED FOR THE 1 UNIT PLAN FOR GI IS $2,500 OR $5,000 ON THE 2 UNIT Plan on a GI basis. On the HCS, they are eligible for a 20% first day plan. The EAP can be GI if an HSP Series or HCS is included. No DI or Accident rider allowed on GI basis. No GI on standalone EAP. The Enhanced Benefit rider or the ER/Urgent care rider are available for GI but if offered everyone must have the rider. The CYM of $100,000 or $250,000 are allowed. No questions need to be answered nor E—Verification	Applicant may apply for up to $40k or $50K of CI benefit and must answer NO to all of the questions. A Phone interview is required.	**Guaranteed Issue** Maximum Benefit Level $6,000 No Questions will need to be Answered. Must have a Primary Medical Policy in force No phone interviews required **Simplified Issue Only** Up to maximum benefit all questions will need to be answered. No phone interviews required
50+	Please check with the Under 65 Marketing Department	Please check with the Under 65 Marketing Department	Please check with the Under 65 Marketing Department	Please check with the Under 65 Marketing Department

Post Sales and Service

- ✔ Check all applications. Do you have all the required information and signatures?
- ✔ Complete the New Business Transmittal.
- ✔ Provide a copy of the New Business Transmittal to payroll administrator.
- ✔ Review the payroll administrator and confirm when the first deductions will start and when the first billing will arrive.

Rules for Contingent Issue Underwriting

The first requirement for an agent to use the eApp for an employer sponsored list bill is that prior to starting the enrollment they receive a **Group Bill Number (GBN)** from the Home Office and complete **Employers Acceptance of List Bill Form 9773**.

In presenting an Employer Bankdraft Program an agent must also receive a Group Bill Number from the Home Office and then send in both the **Employer Bankdraft Acceptance Form 7810** and the **Employer Bankdraft Authorization Form 7812B.**

Important To Remember

1. On payroll deduction business you must set the effective date 6 weeks after you complete the enrollment to allow the payroll clerk enough time to enter the deduction into their payroll system as well as time to deduct the premium amount from at least 2 pay periods.

2. Age is based on the effective date of coverage so make sure you have the correct age quoted otherwise the premium will be incorrect and will cause an amendment and a delay in the group.

3. We only do MONTHLY Bills (24 pay periods—2 pay periods a month) we DO NOT do 13thly (26 pay periods—paid every 2 weeks). We send a bill to the employer 15 days prior to the effective date.

4. All additions to a group must be on the same day of the month as the current employers list bill. We do not allow for multiple billing dates in the same month.

Important To Remember

4. All groups must be pre-approved to receive a Group Bill Number. Email all setup forms to the HO. Please use listbill@neweralife.com

5. If you prefer to fax in your forms please fax forms to 281-368-7240 to receive approval and Group Bill Number and Affiliation Code.

Mailing Address

Attn: New Business
Philadelphia American Life
P.O. Box 4884
Houston, TX 77210-4884

Q&A

Please e-mail additional questions to trainingU65@neweralife.com