



ASSURANT
Health

List Bill Account Agreement for New Business

Instructions - Setting Up the List Bill Account

- Use this form for all employer's except those located in the following states: CO, DE, KY, ID, MD, MN, NC, OR, TN, VA, and WI.
- Complete all information on this form in the Agent Information, Part I and Part II sections and have the employer sign the List Bill Account Agreement. A form without a signature from the employer in Part II will not be accepted.
- Fax the completed and signed List Bill Account Agreement to 414-299-6030.
- Based on your stated preference on the Agreement, you will receive a confirmation email or phone call with the List Bill Account number. Processing time is generally within 24 hours of receipt.
- To immediately obtain an Account number, you can use EASE. Set up your List Bill Account when you submit the first application. The new List Bill Account number will display on the Confirmation Page.

Submitting Applications to the List Bill Account

- Once your account number is established, if you choose to submit applicants via EASE, select "Existing List Bill" as the payment method and enter the account number.
- If you are opting to submit individual applications through a paper process, attach the List Bill Transmittal Form to each application or paper Part 1. The List Bill Transmittal (Form # 29236) is found on Find-A-Form.
- If you are submitting a combined first premium check from the List Bill Account Holder for submitted applications, please also complete the List Bill Combined First Premium (Form # 29239) available on Find-A-Form.



ASSURANT
Health

List Bill Account Agreement for New Business

Agent Information

Agent Name: _____ Writing Agent Number: _____

Agency: _____

Agent Email Address: _____ Agent Phone Number: _____

No contact necessary (*Check this box if account number received via EASE*)

Please contact me regarding account set-up via: Email Phone *If Phone, best time to call:* _____

Part I: Employer Information

Employer Information

Assigned List Bill Number (if known): _____

Name of Business/Entity: _____

Employer Location (State): _____

List Bill Due Date Selected: _____ (*Enter any due date, between 1 and 28*)

Billing Address

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: () _____

Billing Contact Name: _____

Billing Contact Business Email: _____



Part II: Employer Certification

The undersigned employer understands and attests to all of the following:

- The certificates/policies being applied for by employees are individually underwritten and the employer does not consider the individual certificates/policies to be employer sponsored health benefit plans. Additionally, the employer does not pay any portion of the premium for the employee’s health insurance coverage and the employee is not reimbursed in any way by the employer for any portion of the employee’s health insurance premium.
- The employer will payroll deduct 100% of the premium for the enrolled employees and will timely submit all premiums which become due and payable. The employer understands that failure to remit such premium may result in the termination of the List Bill Agreement and may result in the termination of the certificates/policies issued to the employees participating in list bill.
- The employer does not treat the applicant’s health insurance plan as a plan eligible for certain tax advantages under the Internal Revenue Code such as Sections 106, 125, 162, or 220. (Does not apply to Employers with more than 50 full-time employees.)
- The employer understands that this List Bill Agreement does not prohibit the employee from obtaining health insurance from a different carrier. Additionally, the employer is not prohibited from establishing a list bill arrangement with other insurance carriers.
- The employer does not endorse or require employees to apply for Time Insurance Company individual products.
- The employer receives no consideration from Time Insurance Company or any agent in connection with the sale of individual health insurance products.
- Time Insurance Company has the right to terminate the List Bill Agreement at any time for any reason.
- The employer has the right to terminate the List Bill Payment Agreement upon providing at least 30 days written notice to Time Insurance Company and to all employees participating in the List Bill Payment Agreement.
- Any refund of premium issued for any reason will be remitted directly to the policy/certificate holder. There may be limited exceptions as determined by Time Insurance Company.
- For Florida Employers Only: the employer has not administered a group health benefit plan within the last six months.

If this is exclusively established for a 1099 arrangement, the following applies: The word *employer* in this agreement and all subsequent communications is replaced by the term “business entity” and the word *employee* is hereby replaced in this and all subsequent communications with the term “contractor.”

The employer hereby certifies that the above information is correct and true to the best of the employer’s knowledge and belief.

Employer or Designated Representative Signature and Title

Date