



Symetra Life Insurance Company  
Bellevue, WA 98004

**SELECT BENEFITS  
Montana Non-Profit  
Association  
Member Company Set up Form  
Group 10246**

**Mail to:  
Select Benefit Administrators of America  
118 3<sup>rd</sup> Street East  
P.O. Box 440  
Ashland, WI 54806  
1-800-497-3699**

<b>Member Company Legal Name</b>		<b>Administrative Contact and Title</b>	
<b>Street Address</b>		<b>E-mail Address</b>	
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Telephone Number and Fax Number</b>
<b>Mailing Address</b>		<b>Requested Start Date</b>	
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Nature of Business</b>
<b>Case Number 10246 Division _____</b>	<b>Eligible # of Employees</b>	<b>Eligible Classes of Employees</b>	
<b>Plan Selected I544B</b>	<b>Employer Contribution</b>	<b>(monthly) 100% of Core Plan</b>	
<b>Waiting Period for Plan Eligibility: 1<sup>st</sup> of month following:</b>			
<b>Date of Hire</b> <input type="checkbox"/> <b>30 days</b> <input type="checkbox"/> <b>60 days</b> <input type="checkbox"/> <b>90 days</b> <input type="checkbox"/> <b>Other</b> _____ <input type="checkbox"/>			

**Note: All Association Member Set up Forms not fully completed will not be accepted and will be returned to the Agent/Broker**

**Directions:**

1. Complete this form in its entirety.
2. Attach the plan matrix chosen by the employer to the back of this sheet.

**Conditions:**

1. This Association Member Set up Form is subject to acceptance by Symetra Life Insurance Company.
2. This plan is not intended to replace major medical coverage.
3. All necessary administrative information concerning all covered persons shall be subject to the provisions of the policy and shall be furnished to Symetra by the participating employer.
4. All benefits shall be in accordance with those agreed to by Symetra.

**Deposit:**

A deposit of \$ \_\_\_\_\_ is hereby submitted to apply to the first premium payment due under the policy, if issued. Coverage is subject to Symetra Home Office approval and nothing contained herein shall be binding until approved. The deposit will be returned in full if coverage is not issued. Payment of a premium after delivery of the certificate shall constitute acceptance of the terms and conditions.

**Employer's Application and Certification:**

The undersigned employer hereby applies to participate in the Montana Non-Profit Association and for participation in its group insurance coverage as now or hereafter in effect or modified.

I agree that all statements and answers recorded on this application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued.

Signed by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**Servicing Agent's Certification:**

I hereby certify that:

- a) All information set forth above is correct to the best of my knowledge;
- b) I have complied fully with the underwriting guidelines;
- c) I have explained this Association Member Set up Form and the proposed insurance plan in detail to the applicant; and
- d) To the best of my knowledge the above employer is financially sound.

I further certify that all agents involved in presentation of this account

- a) Are licensed by Symetra Life Insurance Company; or
- b) Have submitted the necessary paperwork to become a licensed agent through Symetra Life Insurance Company.

Name (Print) Insurance Coordinators of Montana – Steve Rodgers

Signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_ 39 Neill Ave

Agent License Number 910335

City Helena State MT Zip 59601

Tax ID No. 81-0363375

Telephone No. 406-449-9777 Fax 406-495-03222

Commission Share \_\_\_\_\_ % Symetra Stat. Number

