Beacon Benefits Solution — Many Benefits, One Solution

# Group Private Exchange Checklist

1. Group Name: _____
2. Effective Date: _____
3. Number of Eligible Employees in Group: _____
4. Group Enrollment Date: *(Subject to Carrier Deadlines)*: _____
5. Employer Pay frequency ***(Use an X to select one)*****:** __Monthly __Semi-monthly __Bi-Weekly __Weekly
6. Carrier Products for Enrollment:

| **Carriers:** | **Products:** | **Defined Contribution:** ***(Place an X by one)*****:** |
|---|---|---|
| _____ | _____ | __No __Yes |
| _____ | _____ | __No __Yes |
| _____ | _____ | __No __Yes |
| _____ | _____ | __No __Yes |
| _____ | _____ | __No __Yes |

7. Product Specific Questions ***(Place an X by answers)*****:**
   ***MEDICAL Plans:*** Are Selected Plans HSA-Eligible? __No __Yes
   ***VOL LIFE:*** *a. Include AD&D:* __No __Yes *b. Include Spouse & Child Benefits:* __No __Yes
   *c. Go above Guarantee Issue Amount:* __No __Yes ***(EOI is required for above GI.)***
   ***LTD:*** __100% Employer Paid or __Vol. LTD *(must meet participation)*
   ***STD:*** __100% Employer Paid or __ Vol. STD
   **If electing STD and/or LTD**, please provide current bill and year old bill (w/ full policy booklet) if prior coverage.
   **If electing Dental**, for takeover credit please provide: Current Bill, Schedule of Benefits, & Proof of 12 Months' Coverage.
8. Section 125 Plan? _____
   *(If Yes, provide plan year and which products are subject to the 125 plan)*
9. a. List Pre-Tax benefits: _____
   b. List After-Tax benefits: _____
10. Defined Contribution **"Monthly"** Amounts: ***Ancillary $ Amount:*** _____ ***Medical $ Amount:*** _____
    a. *If applicable, deduct PEPM Technology Fee from Defined Contribution Amount?* __No __Yes
    b. *If applicable, can remaining Medical $ Amount be applied to Ancillary $ Amount?* __No __Yes
11. Subgroup names **(if applicable):** _____
    *(Classes, Multiple Locations, etc.)*
12. Default Employee Elections _____
    *(For employees that do not make elections, specify high/low or specific plans for their enrollment)*
13. Custom Welcome Message *(Brief Instructions for Employees)* – ***Optional*****:** _____
14. HR Admin Contact Name: _____ Email: _____
15. Notification Email Recipient(s) – ***Optional*****:** _____
    *(This email address will receive a notification once each employee has completed their elections. HR Admin, Agent, etc.)*

**16. Please provide the following documents:**

- ✓ Master Application for each product
- ✓ Sold plans/rates for each product
- ✓ Logo *(Provide a file or indicate website)*
- ✓ Signed Online Enrollment System Contract
- ✓ Employee Census to Pre-Populate Employee Information *(Complete attached template)*

***Companion Life Only:***

- Signed Multiple Case Commission Agreement
- Binder check - first month's premium
- Complete Companion's Online Access Form
- Administrative kit sent to the **Agent**, the **Group**, or **Both?** _____

**17. Employer Name:** _____ **Employer Signature:** _____