BAY BRIDGE ADMINISTRATORS

New Business Transmittal

☐ **New Case** ☐ **Adding Product Line(s)**

Please submit completed paperwork to Setup@BBAdmin.com

Customer Information:

Effective Date:

Legal Name: ______________________ Federal Tax ID Number: ____________

Doing Business As (DBA) Name: ______________________ Year [Company] Founded: ____________

Customer's Legal Address (no PO Boxes): ______________________

City: ______________________ State: ____________ Zip Code: ____________

Customer's Mailing Address (if different): ______________________

City: ______________________ State: ____________ Zip Code: ____________

SIC Code used to Rate Group: ____________ Business Industry: ______________________

Total Number of Eligible Employees / Members: ____________

Organization Type: Commercial Employer School Government Union Association Other: ____________

Coverage(s) Sold *(please include signed proposals for all products being offered)***:**

☐ Accident ☐ Cancer & Specified Disease ☐ Critical Illness ☐ Heart/Stroke ☐ Hospital Indemnity/Supplemental Health
☐ Short Term Disability ☐ Long Term Disability ☐ Basic Life ☐ Vol Life ☐ Dental ☐ Vision ☐ MEC ☐ GAP
☐ Major Medical ☐ Admin Duty ☐ MASA ☐ SafetyNet ☐ Telemed ☐ Prescription Discount

Additional Services the group is requesting for Bay Bridge Administrators to provide *(signed Agreements to follow)***:**

☐ Section 125 Administration ☐ COBRA Administration ☐ 403(b)/457(b) Administration

(Please contact your Bay Bridge sales representative for information regarding these additional services)

Will Carrier/Vendor be taking over coverage from a prior carrier/vendor? ☐ No ☐ Yes

If yes, a member census by product and the effective date/copy of the most recent billing statement showing elections for each employee is required with submission.

Contact Information:

Executive Contact

First and Last Name: ______________________ Title: ____________

Email Address: ______________________ Phone Number: ____________ Extension: ______

Benefit Administrator

First and Last Name: ______________________ Title: ____________

Email Address: ______________________ Phone Number: ____________ Extension: ______

Billing Contact

First and Last Name: ______________________ Title: ____________

Email Address: ______________________ Phone Number: ____________ Extension: ______

Billing Information (TPA Billed):

Preferred Invoice Delivery Method:

☐ Electronic – (Balance Bridge) please provide email address and invoice link will be provided via email
____

☐ Deduction Register / Self-Bill – a Remittance detail from the group's own payroll deduction files or worksheets must furnish at least the following information with each remittance: Enrollee Name, SSN or Other Unique ID Number, Premium, and Check for total amount remitted)

Premium Deduction Mode: ☐ Monthly (12) ☐ Semi-Monthly (24) ☐ Bi-Weekly (26) ☐ Other:

BBA Billing Frequency: ☐ Monthly (12) ☐ Semi-Monthly (24) ☐ Bi-Weekly (26) ☐ Other:

Additional Subsidiary / Division / Location Information:

Do you have employees/members who are [actively at work and] are eligible for coverage at other locations *(other than corporate headquarters)*? ☐ No ☐ Yes

If yes, please complete the information below. It is important to list every location and applicable Federal Tax ID Number.

Location #2 Number of Participants at this location: __________ Separate Bill? ☐ No ☐ Yes

Company Name (if different from above): ____________________

Federal Tax ID Number: __________ Location Type: ☐ Subsidiary ☐ Affiliate ☐ Additional Location

Address: ____________________

City: ____________________ State Zip Code: __________

Is the Benefit Administrator Contact for this location the same as the corporate headquarters Benefit Administrator? *(if no, please provide details)* ☐ Yes ☐ No

Benefit Administrator

First and Last Name: ____________________ Title: __________

Email Address: ____________________ Phone Number: __________ Extension: _____

(Please include additional subsidiary / division / locations as an attachment to the form)

Product Eligibility Details – All Employees:

Class Description: ☐ All Active Full-Time Employees Number of Hours Worked per Week: __________

☐ Other: ____________________

Are there Multiple Classes? ☐ No ☐ Yes: ____________________

(If Class Description varies by product or additional space is needed please include as an attachment to this form.)

Waiting Periods:

Present Enrollees: __________ Days ☐ Date Eligible ☐ First of Month Following

Future Enrollees: __________ Days ☐ Date Eligible ☐ First of Month Following

Retirees Covered? ☐ No ☐ Yes (requires prior approval) If Yes: ☐ Closed Class – those retired prior to effective date
☐ Open Class – present and future retirees

Dependents:

Are any mentally or physically handicapped dependent children currently covered? ☐ No ☐ Yes

Are Domestic Partners to be included as eligible dependents (if permitted by state) ☐ No ☐ Yes

If yes:

What domestic partnership types are covered? ☐ Same-Sex Only ☐ Opposite-Sex Only ☐ Both

What is the required timeframe to be eligible? ☐ Immediate ☐ 6 Months ☐ 12 Months ☐ 24 Months

ERISA – MEC Plans Only:

ERISA – a federal law that governs most employer established welfare benefit plans. It is the employer's responsibility to provide certain information to plan participants and the Department of Labor and comply with other requirements. You may obtain additional information about ERISA at www.dol.gov

Are the Policyholder's coverages subject to ERISA? ☐ No
☐ Yes **(If yes, please provide details)**

ERISA Plan Name: ______________________ ERISA Plan Number (i.e. 501, 502, etc): ____________

COBRA ADMINISTRATION – MEC Plans Only:

☐ Employer Administered COBRA
☐ COBRA Administered by Third Party:

COBRA Administration Vendor: ______________________

Address: ______________________

Telephone Number: ______________________

Enrollment Information:

Plan Year: ______________________ To: ______________________

Enrollment Start Date: ______________________ Enrollment End Date: ______________________

Open Enrollment Effective: ______________________ Consistent Across All Products? ☐ Yes ☐ No (please explain)

Enrollment Style: ☐ Every Employee/Member must complete either an Enrollment Form or Waiver
☐ Changes Only – employer continues premium deductions unless Employee/Member submits change

Enrollment Format: ☐ BeneBridge® Platform (BBA's proprietary enrollment/admin platform)
(Please contact your Bay Bridge sales representative for information regarding BeneBridge® services)
☐ Paper Enrollments / Enrollment Spreadsheet
☐ e-App (provided by BBA when a third party enrollment platform is used

Premium Contributions (if varies by product line, please specify):

☐ 100% Employee/Member Paid ☐ Employer Contributes to Premiums as follows:

Percentage for Employee: % Percentage for Dependents: %

Customer Authorizations:

Bay Bridge will deliver the group insurance policy(ies) and certificates via e-mail as Adobe .PDF documents. The Customer confirms that it is able to save them as electronic records and print them (if requested) for distribution to enrollees who become covered under the group insurance policy(ies).

Policies should be delivered (via e-Mail) to: ☐ Producer/Broker to distribute to the Customer
☐ Directly to the Customer, copying the Producer/Broker

Until further advised, We (Customer) agree to honor salary deduction requests signed by our employees/members for insurance issued to them through Bay Bridge Administrators, LLC (BBA) and to forward to BBA [monthly] premiums for which [salary] deductions have been made at the request of our employees/members.

We may, upon reasonable notice to you and to our employees/members, discontinue said deductions, in which event the payment of premiums will be a matter directly between each primary insured and BBA. Written notice of discontinuation will be forwarded to BBA.

We assume no responsibility after the termination of employment of any employee.

Signature of Executive Contact: ______________________ Date: ____________

Producer/Broker Information:

Primary Writing Producer/Broker

Full Legal Name,
as appears on license: ______________________ Tax ID/NPN/BBA Agent Number: ______________

Email Address: ______________________ Phone Number: ______________ Extension: ______

Primary Brokerage/Agency

Full Legal Name,
as appears on license: ______________________ Tax ID/NPN/BBA Agent Number: ______________

Contact, *if different from Producer/Broker*
First and Last Name: ______________________ Title: ______________

Email Address: ______________________ Phone Number: ______________ Extension: ______

Secondary Writing Producer/Broker

Full Legal Name,
as appears on license: ______________________ Tax ID/NPN/BBA Agent Number: ______________

Email Address: ______________________ Phone Number: ______________ Extension: ______

Secondary Brokerage/Agency

Full Legal Name,
as appears on license: ______________________ Tax ID/NPN/BBA Agent Number: ______________

Contact, *if different from Producer/Broker*
First and Last Name: ______________________ Title: ______________

Email Address: ______________________ Phone Number: ______________ Extension: ______

Commissions Payable to: ☐ Writing Producer/Broker ☐ Brokerage/Agency

Commissions Requested: Please include signed proposals.

Commission Split? ☐ No ☐ Yes (must equal 100%)

Agent Name: ______________________ Agent Code: ______________ Split % ______________

Agent Name: ______________________ Agent Code: ______________ Split % ______________

Agent Name: ______________________ Agent Code: ______________ Split % ______________
(Equals 100%)

Producer/Broker Acknowledgement:

As the Producer/Broker of Record, I acknowledge that I am responsible to meet with the Customer Group submitting this Application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries.

Producer/Broker of Record Signature: ______________________ Date: ______________

For Internal Purposes (to be completed by Bay Bridge Administrators: