

AFFILIATION WORKSHEET

Case Name:	
Case Address:	
City, State Zip:	
Employer Representative	
Name & Title:	
Phone:	
eMail:	

Signature of Employer Representative

Date

General Information			
Case Type	<input type="checkbox"/> Association	<input type="checkbox"/> Employer
Is LTCi currently offered or Sponsored?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of Employees/Members		
Location of Employees/Members		<input type="checkbox"/> Single State	<input type="checkbox"/> Multiple States
Association Billing Option			
<input type="checkbox"/> Direct Bill to Member <i>Bill sent directly to Member</i>			
Group Billing Options - EMPLOYER Paid (Note: If buy-ups are allowed, only Monthly and Annual are available)			
<input type="checkbox"/> 100% Employer Paid - Billed to Employer (select one) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Ann <input type="checkbox"/> Annual <i>5 or more applications are required from actively-at-work employees to create one bill to send to Employer.</i>			
Group Billing Options - VOLUNTARY (Includes buy-ups)			
<input type="checkbox"/> Direct Bill to Employee <i>Bill sent directly to employees mailing address.</i>			
<input type="checkbox"/> Payroll Deduction (Monthly Only) (select one) <input type="checkbox"/> 12 Monthly Pay Pds <input type="checkbox"/> 26 Bi-Weekly Pay Pds <i>Requires submission of Payroll Questionnaire and 10 or more applications from actively-at-work employees for payroll deduction.</i>			
Affiliation Commitment			
The above named Affiliation has selected the Agent named below as the Agent of Record to market MedAmerica long term care insurance to all its eligible employees/members. In addition, the Affiliation agrees to support the Agent of Record in the implementation of a communication and enrollment program to all its eligible employees/members.			
Agent Information - Please Print			
Agent of Record Name			
Mailing Address			
City, State, Zip			
Phone Number			
Producer Writing No.			
Email Address			
Supervising Agency			
Supervising Agency eMail			

Agent Signature

Date

Send Completed form to: MedAmerica Sales Dept.

Or Fax Completed Form to: (585) 238-3642

For Office Use Only:			
Approval Signature:		Date:	
Group Number:		Comments:	
Exclusivity:	<input type="checkbox"/> Yes		<input type="checkbox"/> No

* Group exclusivity is at the discretion of MedAmerica.