Flexible Payment Solution (FPS) Agreement

Colonial Life

Please complete this section in its entirety:

Account name: _____

Account street address: _____

City:_____State:_____Zip: _____

Account mailing address: _____

City:_____State:_____Zip: _____

Phone:_____-_____-_____ext:_____ Employer Identification Number (EIN): _____

If this account is associated with any other Colonial Life & Accident Insurance Company accounts or one of its affiliates, please provide the name and Billing Control Number (BCN) of the account or Master Group Number:

_____

Account website: _____

Date company was established: _____

Give an exact description of the nature of business: _____

_____

Total number of benefit eligible employees: _____

Are any of the above contracted via 1099?: ☐ Yes ☐ No If so, how many?_____

Multiple State Enrollment? ☐ Yes ☐ No

Will enrollment occur in NY? ☐ Yes ☐ No

Targeted coverage effective date: _____

Important Compensation Disclosure Information

Colonial Life & Accident Insurance Company (hereafter Colonial Life) is committed to helping working Americans and their families minimize personal financial risk with a comprehensive offering of voluntary benefits through the workplace. Colonial Life compensates producers to facilitate the sale and delivery of these valuable benefits. This compensation might include commissions as well as various incentives and awards. We support the full disclosure of compensation programs for our products, and your insurance advisor can provide you with complete information about these programs. You may also learn additional information about our compensation programs by contacting our Plan Administrator Service Center at 1.800.256.7004.

Is employer/account paying a fee to an insurance advisor for this placement of Colonial Life insurance?

☐ Yes ☐ No Initials of Authorized Officer _____

If yes, list advisor(s) names: _____

A completed Compensation Consent Disclosure Form is required for each insurance advisor receiving a fee. If a fee is paid in the future it is the account's responsibility to notify Colonial Life of the change.

Agreement

I agree to the following:

1. Personnel who are eligible and desire to do so may apply to become insured under available coverages issued by Colonial Life while at work.
2. I affirm that premiums for Colonial Life coverage cannot be payroll deducted from employee's pay and remitted on their behalf.
3. I will provide any additional verifications or authorizations that Colonial Life may require.

It is understood that because all premium payments will be made on an individual basis, the employer will not be liable for any unpaid premiums.

Name and title of authorizing officer: _____

Signature of authorizing officer: _____

Phone:_____-_____-_____Email address: _____

Date: _____

PRODUCER

I, (producer name)_____, certify to the best of my knowledge, the information above is accurate and true.

Signature:_____Code: _____

Date:_____Producer's phone:_____-_____- _____