TRANSMITTAL FORM

Trustmark
Voluntary Benefit Solutions

Date: _____

ATTENTION: Group Implementation Team • Dept. P683 • Trustmark Insurance Company
400 Field Drive, Lake Forest, Il 60045 • (800) 229-4543 • FAX (847) 615-3140
GIT@trustmarkinsurance.com

This is Batch _____ **of** _____. This is a Completed Enrollment ____ Yes ____No If no, approximately what date will the enrollment be completed? _____ DDS Discount Card ____ Yes ____No

EMPLOYER INFORMATION: _____

Legal Employer Name: _____

Subsidiaries: _____

Contact Person/Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number:(_____)_____ Fax Number: (_____)_____

CERTIFICATE/POLICY MAILING INFORMATION:

Mail to Employee's Home ____ *Other _____ Specify _____

BILLING INFORMATION:

Mequon Billing Yes ___ No ___ Information Needed By _____ (To be completed by Mequon)

Billing Contact Person: _____

Billing Address: _____

Telephone Number: _____ Fax Number: _____

Email: _____

Billing Type: *(Paper) List Bill ____ *(Paperless) Magnetic Media Bill ____ If selected, please specify name/telephone number of technical support person.

Name: _____ Phone: _____

*Other _____ Specify _____

Billing Frequency: • Monthly _____ • Other _____ • Specify _____

Deduction Mode: (# of deductions taken per year for insurance)

• Weekly _____ • Biweekly _____ • Monthly _____ • 9 Months/Yr. Paid _____

• 10 Months/Yr. Paid _____ • Semi Monthly _____ *Semi Monthly Deduction dates, 1st & 15th ____ or 15th & 30th ____ or other _____

* Other _____ Specify _____

Sort Preference for List Bill: Alphabetical ____ Employee ID # _____ Employee Social Security # _____

First Payroll Deduction Date: (Mo./Day/Year): _____

* If more than one mode with different dates please list date for each mode.

Policy Effective Date: (Mo./Day/Year): _____

First Deduction Register Required: Yes _____ No_____ Date Needed _____

Format: Paper _____ Disk _____ Tape _____

AGENCY (WES) INFORMATION:

Agency Name: _____

Agent Contact/Title: _____

Agency Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____ Fax Number: (_____) _____

Email: _____

COMMISSION INFORMATION (please indicate commission percentages as a % of premiums):

LIFE	Name on Contract	Code Number	Commission Percentage Year 1	Year 2 to ____	Year ____
	1.				
	2.				
	3.				

CANCER/CRITICAL ILLNESS

	1.				
	2.				
	3.				

DISABILITY

	1.				
	2.				
	3.				

TERM ALTERNATIVE

	1.				
	2.				
	3.				

HOSPITAL INDEMNITY

	1.				
	2.				
	3.				

ACCIDENT

	1.				
	2.				
	3.				

Wes # _____, Name _____

Servicing Agent # _____, Name _____

Production Agent # _____, Name _____

NOTE: Anyone taking applications must be appointed/licensed in the state of enrollment. Business will not be processed unless each party to receive commissions is contracted, and appointed/licensed by Trustmark.

NOTE: Before submission all cases must be issued a formal underwriting quote by Case Management. Call 800-840-4692 if no underwriting quote has been obtained. Attach quote for each product enrolled, to first transmittal of group.