PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

# List Bill New Business Transmittal
# - Contingent Issue-

List Billing Plan: ☐ New Plan or ☐ Addition to Plan

Date

Name of Company | Company Phone # | List Bill #

Billing Address

City | State | Zip

Payroll Contact | Phone Number (Extension) | Email Address

Agent Name | Agent # | Agent Phone Number | Agent Email Address

Initial Premium ☐ Check Enclosed ☐ Bill Account Billing Frequency: ☐ Monthly ☐ Other

*Mode of payment other than monthly requires prior Home Office Approval

New employees are eligible for benefits in: ☐ 30 days ☐ 60 days ☐ 90 days ☐ days

Requested Effective Date | Date of 1st Payroll Deduction | Number of Eligible Employees

Send Policies to: ☐ Agent ☐ Employer ☐ Employee List Bill/Application Fee $

Indicate the type of policy being applied for within this enrollment. List all applicants below or attach equivalent census:

| Name of Applicant Last, First MI (Please Print) | Employment Date For New Employee Additions | Plan Type | Last 4 Digits of Employee's SS# | Monthly Deduction Amount | If employee did not elect to participate in the health insurance program please explain: |
|---|---|---|---|---|---|
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| 15. | | | | | |

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees listed above have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

SIGNATURE OF ADMINISTRATOR DATE