

List Bill New Business Transmittal Form

List Billing Plan: New Plan or	☐ Addition to Plan					
					Date	
Name of Company	me of Company Phone #			List Bill #		
Billing Address						
City	State			Z	Zip	
Payroll Contact	Phone No	Phone Number (Extension)			mail Address	
Agent Name	Agent #	gent # Agent Phone Number			Agent Email Address	
Initial Premium	emium Check Enclosed Bill Account Billing Frequency:			ncy: \square Mo	y:	
*Mode of	f payment other than mo	onthly requires	s prior Home (Office Approv	al	
Requested Effective Date			Date of 1 st	Date of 1 st Payroll Deduction		
					List Bill/Application Fee \$	
_		-	et all applicar			
Indicate the type of policy being app	nied for within this em	Ollment. Lis	Last 4		attach equivalent census.	
Name of Applicar Last, First MI (Please		Plan Type	Digits of Employee's SS#	Monthly Deduction Amount	If Coverage for a Dependent Only- Provide Name of Employee	
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2.						
3.						
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