MultiLife Business Program

SYMETRA
RETIREMENT | BENEFITS | LIFE

MultiLife Company Submission Form

General information

Date

Financial professional name

BGA office name

Company information

Company name

Company physical address (must be in the U.S.)

Company web address

Industry or nature of business

Number of years in business

Family-owned or controlled? ☐ Yes ☐ No

Holding company? ☐ Yes ☐ No

Company structure

- ☐ LLC/LLP
- ☐ C corporation
- ☐ S corporation
- ☐ Partnership
- ☐ Sole proprietor
- ☐ Other. Please describe: _____

Company financial information
(must be included with this submission)

- ☐ Current financial statements
- ☐ Most recent tax returns (2 years)

Plan information

Purpose of the coverage

Number of eligible employees

What percentage of eligible employees will participate?

How will group eligibility be defined?
(For example, all full-time employees at the vice president level and above)

Total requested specified amount

Total first-year premium

What formula will be used to determine the coverage amounts requested for each eligible employee?

Will this coverage replace or supplement existing coverage for eligible employees in the group?

☐ Yes, ☐ Individual ☐ Group
☐ No
If replacing, please provide details on existing coverage:

If additional, please note the existing carrier information:

Will the coverage be stacked with another carrier's?

☐ Yes ☐ No
If Yes, please explain:

Will premium financing be used for all eligible employees in the group?

☐ Yes ☐ No
Note: Please provide our premium financing rules to the client.

Are all proposed participants W-2 salaried employees of the company?

☐ Yes ☐ No

Have any eligible employees ever had life insurance applications rated or declined or had significant poor health history?

☐ Yes ☐ No
If Yes, please explain:

Are any eligible employees required to travel to perform work duties to countries on the U.S. Travel Advisory List?

☐ Yes ☐ No
If Yes, please explain:

Have any proposed participants been hospitalized or absent from work due to illness or accident more than a total of three days in the preceding three months?

☐ Yes ☐ No (Please note: Anyone who indicates yes to this question will not qualify for the program.)

Are all proposed participants currently engaged in active, full-time work (at least 30 hours per week, five days a week) in a normal capacity at their regular place of employment?

☐ Yes ☐ No (Please note: Anyone who indicates no to this question will not qualify for the program.)

Ownership by the company, trust or individual insureds?

☐ Company ☐ Company trust ☐ Individual insureds

State in which the case will be written (if company-owned)

Requested policy date (if other than the final date monies/applications are received). Note: Cannot be the 14th, 29th, 30th, or 31st of the month.

Company contact information

Company contact name

Company contact email

Company contact phone

Contact us

Symetra MultiLife Business Team
1-877-737-3611
multilifesales@symetra.com

SYMETRA®
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com