



## Employer Agreement for List Bill Administration

By signing this List Bill payroll deduction form, I \_\_\_\_\_, on behalf of  
(print name)

\_\_\_\_\_, certify and acknowledge that the employees listed on the "List Bill  
"company"  
Applicants Worksheet" have applied, or are applying for Medical Mutual's SuperMed One personal health insurance policy.

I also certify that neither Medical Mutual nor I intend for these personal health coverage policies to be an employer sponsored health benefit plan. The Company has not endorsed such policies to these employees and has not agreed to directly or indirectly reimburse any employee for any portion of the premium for these policies.

I also certify that I have not represented to any employee that these policies billed to my place of business are guaranteed issue or that they are benefits provided by the Company.

I agree that I will deduct from each participating employee's payroll the amount of the premium for that employee. Such amounts will be promptly remitted to Medical Mutual in accordance with the requirements of this List Bill arrangement.

I further acknowledge that Medical Mutual has advised me to seek competent legal and tax advice to ensure compliance with applicable laws and regulations as they relate to the establishment of this List Bill payroll deduction arrangement.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Business Name \_\_\_\_\_

Billing Contact \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

# List Bill Applicants Worksheet

Company name \_\_\_\_\_ Date \_\_\_\_\_

*Please list all applicants with initial submission.  
When adding employees to List Bill, only include names of the additional employees.*

1. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
2. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
3. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
4. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
5. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
6. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
7. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
8. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
9. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
10. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
11. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
12. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
13. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
14. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
15. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life
16. Last name	First name	Middle initial	Social Security Number	Plan type (circle) 500 1000 1500 2500 5000 Vision Dental Life

Signed : \_\_\_\_\_ Date: \_\_\_\_\_

(billing contact)