

# LIST BILLING/EFT AGREEMENT

For use with List Billing Option:

The Employer and Agent must sign and attach the following statement when submitting List Bill applications to American Community Mutual Insurance Company (ACMIC).

## EMPLOYER

Employer Name \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_

Billing address (if different) \_\_\_\_\_

City/State \_\_\_\_\_

Employer Contact \_\_\_\_\_ E-mail Address \_\_\_\_\_

Contact Phone \_\_\_\_\_ Contact Fax \_\_\_\_\_

The Employer understands and agrees that:

- The Employer will collect premiums and fees from applicants and submit these monies to ACMIC on behalf of the applicant by the payment due date.
- The Employer will not make any contribution now or in the future to any portion of the applicants' premiums or fees.
- The Employer will not reimburse the applicants for premium or fees.
- The Employer agrees that the applicant is applying for individual coverage that is not intended to be an employer-sponsored health insurance plan as defined by federal or state law.
- The Employer will not claim any tax benefit now or in the future for any monies remitted.
- The Employer will not obtain any information regarding the insurance except for the amount of premium and fees without the written authorization of the employee.
- The Employer understands and agrees that any premium refunds that may be due will be sent directly to the applicant.
- The Employer understands and agrees that ACMIC may cease the List Billing Agreement at its discretion upon giving 30 days notice to the Employer.
- The Employer understands that the applicant can continue coverage by submitting premiums and fees to ACMIC directly.
- The Employer accepts no responsibility for collecting and submitting premium and fees for applicants after the List Bill Option ceases.

\_\_\_\_\_  
Signature of Employer/Authorized Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name of Employer/Authorized Representative

\_\_\_\_\_  
Date

## AGENT

I certify that I have accurately and truthfully recorded all the information given to me by the Employer and confirm the Employer's understanding of the terms set forth above. I have personally witnessed the signing of this agreement by the Employer's authorized representative. I certify that I have explained to the Applicants that they will be submitting applications for Individual Insurance and that the Employer will pay no part of the premium or fees.

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Agent #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Employer/Authorized Representative