WBA Employer List Bill Agreement

Name of Employer: _____ Contact: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____ Contact Email : _____

Please Calculate Total Monthly Dues Below

	Choose Plan and the # of Employees	Emp		Dues		Totals
1	$2500 Basic Employee Only (Emps times Dues)	____	x	$_____	=	$_____
2	$2500 Basic Full Family (Emps times Dues)	____	x	$_____	=	$_____
3	$2500 PLUS Plan Employee Only (Emps times Dues)	____	x	$_____	=	$_____
4	$2500 PLUS Plan Full Family (Emps times Dues)	____	x	$_____	=	$_____
1	$5000 Basic Employee Only (Emps times Dues)	____	x	$_____	=	$_____
2	$5000 Basic Full Family (Emps times Dues)	____	x	$_____	=	$_____
3	$5000 PLUS Plan Employee Only (Emps times Dues)	____	x	$_____	=	$_____
4	$5000 PLUS Plan Full Family (Emps times Dues)	____	x	$_____	=	$_____
5	$7500 Basic Employee Only (Emps times Dues)	____	x	$_____	=	$_____
6	$7500 Basic Full Family (Emps times Dues)	____	x	$_____	=	$_____
7	$7500 PLUS Plan Employee Only (Emps times Dues)	____	x	$_____	=	$_____
8	$7500 PLUS Plan Full Family (Emps times Dues)	____	x	$_____	=	$_____
9	$10,000 Basic Employee Only (Emps times Dues)	____	x	$_____	=	$_____
10	$10,000 Basic Full Family (Emps times Dues)	____	x	$_____	=	$_____
11	$10,000 PLUS Plan Employee Only (Emps times Dues)	____	x	$_____	=	$_____
12	$10,000 PLUS Plan Full Family (Emps times Dues)	____	x	$_____	=	$_____
A	Recurring Monthly Rates (Lines 1 thru 12)					$_____
B	Total Participating (Lines 1 thru 12 times $5.00)	____	x	$5.00	=	$_____
	1st Month Only (Line A plus Line B)					$_____

Number of Participating employees: _____ Plan effective date: ____/01/20____
1st of the month only

Until further notice, the Employer agrees to deduct from Employee's salaries or wages for the membership dues under the **WBA Accident Shield** plan and to forward said dues to **WBA** care of **Comprehensive Insurance Agency, LLC**.

The Employer assumes no other liability under this agreement and has the right to discontinue it at any time after 30 days notice, in which case the payment will become a matter of arrangement between employee and company. Employer does not agree to handle the payment of any dues after termination of an employee's service. This undersigned employer agrees to the conditions printed above and assumes no liability other than as specified.

We certify that no portion of the dues or benefits of the plan for which our employees have applied will be paid by us (the employer), or reimbursed to our employees or dependents by wage adjustment or in any other manner for any portion of the dues or benefits, nor will the plan be treated by us as part of a plan or program for the purpose of our taking a deduction for such premium under Sections 106, 125 (except Texas), or 162 (except 162(l)) of the Internal Revenue Code.

Company Name:_____

Authorized Signature: _____ Date: _____

WBA c/o Comprehensive Insurance Agency, LLC
3601 Algonquin Rd, Suite 605 - Rolling Meadows, IL 60008
847-483-9484 888-384-5888 fax 847-483-9485