



**OPTIONAL AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PREMIUM PAYMENTS**

I authorize Allied National to charge my account as indicated below for my monthly insurance premium and fees. I understand my account will be charged once each month for the total amount shown as due on my monthly premium statement for the limited term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse prior to its termination date. I understand that if I wish to cancel my coverage prior to its termination date, I must inform Allied National of such cancellation prior to the end of the grace period corresponding to the date of cancellation. Please charge my monthly premium and fees against the following account.

NAME (as shown on account – please print) \_\_\_\_\_

CREDIT CARD:  MasterCard  Visa – Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

CHECKING/NOW ACCOUNT: Please attach a voided check from the account you wish billed for your coverage.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**OREGON AREA FACTORS**

(based on first 3 digits of zip code of the residence address)

972, 973, 975 – 977 ..... 1.50  
 970, 971, 974, 978, 979..... 1.40

***This Plan is available in other states. Please contact Allied for state availability.***

**RATES/AREAS EFFECTIVE 10/01/11**

\$500 Deductible			\$1,000 Deductible			\$1,500 Deductible			\$2,500 Deductible		
Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.	Age	Male	Fem.
0-29	\$50	\$61	0-29	\$43	\$51	0-29	\$35	\$42	0-29	\$27	\$33
30-34	\$58	\$75	30-34	\$49	\$64	30-34	\$40	\$52	30-34	\$32	\$41
35-39	\$72	\$91	35-39	\$61	\$77	35-39	\$49	\$63	35-39	\$39	\$50
40-44	\$87	\$108	40-44	\$74	\$91	40-44	\$60	\$74	40-44	\$47	\$58
45-49	\$108	\$122	45-49	\$91	\$104	45-49	\$74	\$84	45-49	\$58	\$66
50-54	\$138	\$149	50-54	\$117	\$126	50-54	\$95	\$102	50-54	\$75	\$81
55-59	\$194	\$180	55-59	\$165	\$152	55-59	\$133	\$123	55-59	\$106	\$98
60-64	\$263	\$241	60-64	\$223	\$204	60-64	\$181	\$166	60-64	\$143	\$131
Per Child .....	\$43		Per Child .....	\$37		Per Child .....	\$30		Per Child .....	\$24	
Supplemental Accident Rate	Per Person .....		Supplemental Accident Rate	Per Person .....		Supplemental Accident Rate	Per Person .....		Supplemental Accident Rate	Per Person .....	
	\$5			\$5			\$5			\$5	

RATE LOAD FACTORS		
EFFECTIVE DATE	PREPAY	MONTHLY
10/1/11 – 12/31/11	1.00	1.33
1/1/12 – 3/31/12	1.03	1.37
4/1/12 – 6/30/12	1.06	1.41
7/1/12 – 9/30/12	1.09	1.45
10/1/12 – 12/31/12	1.12	1.49

A. Applicant \$ \_\_\_\_\_  
 B. Spouse +\$ \_\_\_\_\_  
 C. Child(ren) +\$ \_\_\_\_\_  
 D. Subtotal =\$ \_\_\_\_\_  
     Area Factor X \_\_\_\_\_  
     Load Factor X \_\_\_\_\_

**E. Premium Subtotal**  
**(round to nearest \$)** =\$ \_\_\_\_\_  
 F. Supp.Acc.Option +\$ \_\_\_\_\_  
 G. Monthly Fee +\$ **12.00**  
 H. Total Monthly Cost =\$ \_\_\_\_\_

**PREPAY PLAN ONLY**  
 I. Number of Months X \_\_\_\_\_  
 J. Prepay Total Cost =\$ \_\_\_\_\_

**RATE CALCULATION:**

1) Determine rates based on deductible chosen and sex and age of each person. For child(ren) rate multiply number of children by the per child rate.

2) Multiply the subtotal (D) of these rates by the Area Factor and the Rate Load Factor to get Premium Subtotal (E) and round to nearest dollar. The Rate Load Factor is determined by the requested effective date and whether choosing Prepay or Monthly billing.

3) Add rates for optional Supplemental Accident coverage if applicable.

Supplemental Accident rate is for each person applying (e.g. if applicant, spouse and 1 child apply, the rate is 3 times \$5 for a rate of \$15).

4) Add Monthly Fee to get Total Monthly Cost (H).

5) For Prepay ONLY – multiply H times number of months requested for Prepay total Cost (J).

**NOTE- Business checks cannot be accepted. Payment must be made by credit card or personal check payable to Allied National.**

**Online enrollment and rating is available at tempmedsales.alliednational.com.**

**AGENT INFORMATION**

SOLICITING A GENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Soliciting Agent's Name \_\_\_\_\_ Agency \_\_\_\_\_ Allied Agent# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel ( ) \_\_\_\_\_ Pay Commissions to: \_\_\_\_\_ SS# or Tax ID# \_\_\_\_\_

Fax ( ) \_\_\_\_\_ EMAIL \_\_\_\_\_

**1) Is the soliciting agent a licensed agent in the applicant's state of residence?**  
 Yes – If Yes, please send copy of state license.  No – If No, the agent is not authorized to solicit this coverage and the policy cannot be issued.

**2) Is the soliciting agent currently appointed with American Alternative Insurance Corporation:**  
 Direct with American Alternative Insurance Corporation? Or  Through ALLIED or another Administrator? WHO? \_\_\_\_\_

**Appointment fees:** Allied National will pay fee for agent appointment.

**DISTRIBUTOR/GENERAL AGENT NAME:** \_\_\_\_\_