

AGENT REQUEST FOR PROPOSAL



How to submit a proposal request:

1. Fill out agent and client information in its entirety.
2. Select plan(s) you wish quoted and the benefits for each plan selected.
3. Complete census information on reverse for all individuals to be insured.
4. Mail (or fax) completed form to Allied National. For questions, call Allied's Sales Support Team.

888-767-7133
Fax 913-945-4396
Email: sales@alliednational.com
Web: www.alliednational.com

AGENT INFORMATION:

Agent Name _____ Agent # _____
 Agency Name _____ Overwrite # _____
 Phone # () _____ Fax # () _____ Email _____

CLIENT INFORMATION:

Name _____ SIC _____
 Nature of Business _____
 City _____ State _____ Zip _____ County _____
 Requested Effective Date _____

BENEFIT INFORMATION: Check appropriate box for each plan quote desired.

ADMIN USE ONLY
 Add Load _____

- PROVIDER FREEDOM** (No PPO network required)
 PPO NETWORK CHOICE _____

<input type="checkbox"/> WELLNESS HORIZONS[®] <input type="checkbox"/> FUNDING ADVANTAGE (check one or both) <i>Not all benefit combinations are available. See Allied proposals for details.</i>		
<p style="text-align: center;">Premium Advantage</p> <p>Annual Office Visits with a copay, balance subject to deductible <input type="checkbox"/> Unlimited <input type="checkbox"/> 2x limit <input type="checkbox"/> 4x limit</p> <p>In-Network Office Visit Copay¹ <input type="checkbox"/> None <input type="checkbox"/> \$30 <input type="checkbox"/> \$35 <input type="checkbox"/> \$40</p> <p>Deductible <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000</p> <p>Coinsurance Percentages listed as in-network/out-of-network. <input type="checkbox"/> 50%/50% <input type="checkbox"/> 70%/50% <input type="checkbox"/> 80%/50% <input type="checkbox"/> 100%/70%</p> <p>Out-of-Pocket Maximum <input type="checkbox"/> \$0/\$6,000** <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,000/\$6,000 <input type="checkbox"/> \$4,000/\$8,000 <input type="checkbox"/> \$5,000/\$10,000 <input type="checkbox"/> \$7,500/\$15,000 <input type="checkbox"/> \$10,000/\$20,000</p> <p>** Available with 100%/70% coinsurance only</p> <p>Prescription Drug Options <input type="checkbox"/> Discount card <input type="checkbox"/> Generic Only <input type="checkbox"/> \$150/\$1,500 <input type="checkbox"/> \$0/unlimited <input type="checkbox"/> \$150/unlimited <input type="checkbox"/> \$250/unlimited <input type="checkbox"/> \$350/unlimited <input type="checkbox"/> \$500/unlimited <input type="checkbox"/> Deductible Integrated <input type="checkbox"/> \$3/\$10/\$30/\$50</p>	<p style="text-align: center;">Provider Freedom</p> <p>Annual Office Visits with a copay, balance subject to deductible <input type="checkbox"/> Unlimited <input type="checkbox"/> 2x limit <input type="checkbox"/> 4x limit</p> <p>In-Network Office Visit Copay¹ <input type="checkbox"/> None <input type="checkbox"/> \$30 <input type="checkbox"/> \$35 <input type="checkbox"/> \$40</p> <p>Deductible <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000</p> <p>Coinsurance <input type="checkbox"/> 50% <input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 100%</p> <p>Out-of-Pocket Maximum <input type="checkbox"/> \$0** <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000</p> <p>** Available with 100%</p> <p>Prescription Drug Options <input type="checkbox"/> Discount card <input type="checkbox"/> Generic Only <input type="checkbox"/> \$150/\$1,500 <input type="checkbox"/> \$250/unlimited <input type="checkbox"/> \$350/unlimited <input type="checkbox"/> \$500/unlimited <input type="checkbox"/> Deductible Integrated</p>	<p style="text-align: center;">HSA Qualified</p> <p>Deductible <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000</p> <p>Coinsurance and Out-of-Pocket <input type="checkbox"/> 100%/70% <input type="checkbox"/> 80%/50% <input type="checkbox"/> \$0/\$6,000 <input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,000/\$4,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,000/\$6,000</p> <p>Prescription Drug Options <input type="checkbox"/> None <input type="checkbox"/> Deductible Integrated <input type="checkbox"/> \$3/\$10/\$30/\$50 <input type="checkbox"/> \$0/\$0/\$0/\$60</p> <p style="text-align: center;">HSA Provider Freedom</p> <p>Deductible <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000</p> <p>Coinsurance and Out-of-Pocket <input type="checkbox"/> 100% <input type="checkbox"/> 80% <input type="checkbox"/> \$0 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000</p> <p>Prescription Drug Options <input type="checkbox"/> None <input type="checkbox"/> Deductible Integrated <input type="checkbox"/> \$3/\$10/\$30/\$50 <input type="checkbox"/> \$0/\$0/\$0/\$60</p>

¹ Office visit copays do not apply to deductible or out-of-pocket maximums.

MAJOR MEDICAL ADDITIONAL COVERAGE OPTIONS (Check desired benefit.)

- OCCUPATIONAL COVERAGE** — owners, partners, and corporate officers NOT covered by Workers Compensation may elect to be covered on a 24-hour basis under this Plan. If elected, all eligible owners, partners, and corporate officers must take this coverage.
- PREGNANCY COVERAGE** — available to groups initially insuring five or more eligible employees (four or more in Ohio) with health coverage. Covered as any other illness. (Included for all Funding Advantage plans.)
- \$500 SUPPLEMENTAL ACCIDENT BENEFIT** — pays 100% of charges incurred by an accident up to a \$500 benefit. (Available on the Premium Advantage plans only.)
- LIFE EXTRA COVERAGE OPTION** — \$10,000 (minimum amount) to \$50,000 (maximum amount) Other amount \$ _____ By class (set up classes by job or income)

ALLIED™ COST SAVER (Groups of 2+. Check desired plan.)

Plan: 500 Value 750 Basic 1,000 Standard 1,500 Superior

Deductible: \$250 \$500

Pregnancy – Available to groups initially insuring five or more eligible employees (four or more in Ohio) with health coverage. Covered as any other illness.

Optional Life – \$10,000 standard for each employee

Prescription Drug Options:

Generic Only \$15 copay per prescription. Brand name drugs provided at Allied's contracted discount.

Formulary: \$75/\$500 \$150/\$1,500

ALLIED™ COREVALUE HEALTH PLAN (Groups of 2-50. Check desired plan.)

<input type="checkbox"/> Employer Pay Deductible: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 Supplemental Options: Out Patient <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 Hospital <input type="checkbox"/> \$2,500	<input type="checkbox"/> Voluntary Deductible: <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000
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Major Medical:

Pregnancy – Available to groups initially insuring five or more eligible employees (four or more in Ohio) with health coverage. Covered as any other illness.

Occupational – owners, partners, and corporate officers NOT covered by Workers Compensation may elect to be covered on a 24-hour basis under this Plan. If elected, all eligible owners, partners, and corporate officers must take this coverage.

Prescription Drug Options:

Generic Only: \$15 copay per prescription. Brand name drugs provided at Allied's contracted discount.

Deductible Integrated

Formulary: \$150/Unlimited \$250/Unlimited \$350/Unlimited \$500/Unlimited

ALLIED™ LIFE & DISABILITY (Groups of 2-99. Check desired plan.)

Please contact Allied Sales Support at (888) 767-7133, for a separate Life/Disability Request for Proposal form.

Benefits Requested: Life/AD&D STD LTD

ALLIED™ DENTAL DESIGN (Groups 2-99. Check desired plan.)

Annual Maximum Benefit: \$750 \$1,000 \$1,500 \$2,000

Deductible: \$50 Calendar Year \$75 Calendar Year \$100 Lifetime

Takeover Yes No

Orthodontia: Yes No

Orthodontia Takeover: Yes No

Enhanced Option: Yes No

DD Quick Quotes			
I _____	C _____		
S _____	F _____		

ALLIED™ SHORT TERM MEDICAL PLUS Deductible: \$500 \$1,000 \$1,500 \$2,500 \$5,000 \$7,500 \$10,000

CENSUS INFORMATION (If additional space is needed, please use separate sheet and attach to this form.)

Name, Class & Benefit Amount (class & benefit amount for Life/WDI Cases)	DOB/AGE	SEX	Coverage Type I-S-C-F	Number of Children	Spouse's DOB/AGE	Owner, Officer, Partners Y/N	Monthly Salary	STD Weekly Benefit	LTD Flat Benefit Amount	Term Life Benefit Amount
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										

Coverage Type:

I = Insured
 S = Insured and Spouse
 C = Insured and Children
 F = Insured, Spouse and Children

Owner, Officer, Partner Monthly Salary
STD Weekly Benefit
Life Benefit Amount
LTD Dollar Amount

Yes or No answer determines eligibility for Occupational Coverage option under Allied Health Plans.
 Used to determine disability benefits (if applicable).
 For STD Disability income, enter dollar amount (0 to \$1,000 in even \$10) or percentage (40-60%).
 \$10,000 to \$100,000 in even \$1,000 increments or a percentage of annual salary (1, 1.5, 2, 3, 4, 5)
 (\$500-\$6,000) in even \$100 increments or percentage (40-66%).

Mail To: Allied National P.O. Box 29189 Shawnee Mission, KS 66201-9189

Phone: 888-767-7133 Local: 913-945-4100 Quote Fax: 913-945-4396 Web: www.alliednational.com Email: sales@alliednational.com