



ALLIED™ COST SAVER EMPLOYEE ENROLLMENT FORM
 Enrollment with American Alternative Insurance Corp., Princeton, NJ
 May be Photocopied or Duplicated for use. Please complete in ink.



SECTION 1 – APPLICANT INFORMATION

FULL NAME OF EMPLOYEE			MARITAL STATUS	GENDER (M/F)	ADM. Use Only	
RESIDENCE ADDRESS			CITY	STATE		ZIP
TELEPHONE NUMBER (include area code)			Best time to contact (if additional information is required by Insurance Company)			
AGE (last Birthday)	BIRTHDATE (mm/dd/yy)	DATE BEGAN FULL TIME (mm/dd/yy)	SOCIAL SECURITY NUMBER			
EMPLOYED BY		EMPLOYER'S PHONE (include area code)	AVG. NO. HOURS WORKED WEEKLY	MONTHLY EARNINGS	\$	
EMPLOYER'S LOCATION – STREET ADDRESS		CITY	STATE	ZIP	EFFECTIVE DATE	
OCCUPATION AND DUTIES		LIFE INSURANCE BENEFICIARY AND RELATIONSHIP				
<input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER					UWF 48 YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____	
I am applying for (check one): <input type="checkbox"/> SELF ONLY <input type="checkbox"/> SELF AND SPOUSE <input type="checkbox"/> SELF AND CHILD(REN) <input type="checkbox"/> SELF, SPOUSE, & CHILD(REN)					UWF 40 YES <input type="checkbox"/> NO <input type="checkbox"/>	

DEPENDENT INFORMATION					ADMIN USE ONLY	
Complete for spouse and each dependent child to be insured. (Use additional sheet if necessary.)					D&R Y/N	PXT
NAMES OF DEPENDENTS	RELATIONSHIP	GENDER (M/F)	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
1. Employee Name	Self					
2.						
3.						
4.						
5.						
6.						

SECTION 2 – PRIOR INSURANCE COVERAGE CREDIT

Have you or your dependents been covered under any health insurance plan within the last 90 days? YES NO
 If Yes, to qualify for prior coverage credit, please provide the following information on all coverage in force in the past 12 months - Please note that most of this information can be obtained from your current Insurance Identification Card:

Name of Insurance Company _____ Ins. Co. Phone Number () _____
 Effective date of Prior Coverage* _____ Coverage is still in force and paid through (date) _____
 Coverage Termination Date _____ Reason for Coverage Termination _____

Type of Coverage employer sponsored _____ Company Name _____ Policy/Cert. Number _____
 Individual (**Select one:** Temporary Permanent) _____ Company Name _____ Policy/Cert. Number _____

Coverage was for (check all that apply): Self Spouse Children

❖ We need confirmation of your coverage with your prior carrier. Please provide us with a copy of the Certificate of Creditable coverage provided by the carrier.

RETURN APPLICATION TO ALLIED NATIONAL • UNDERWRITING • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187
 Electronic copies of this application submitted via facsimile, e-mail or other electronic means shall be deemed an original.

SECTION 3 – APPLICANT STATEMENT & SIGNATURE

I hereby apply for the supplemental, limited benefit insurance to which I am now or may become entitled to under the provisions of the Master Policy issued by the Insurance Company. I authorize my employer to pay premiums and to deduct any required premium contribution from my earnings. I understand that my employer is being authorized to pay premium, is my agent and not the agent of the Insurance Company, and that my insurance may be terminated if premiums are not paid by my employer as required.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be found guilty of insurance fraud in a court of law. I understand that my coverage, if approved, and that of my eligible dependents, will be subject to the pre-existing condition and replacement of coverage provisions specified in the Master Policy. I understand that, subject to the replacement of coverage provisions of the Master Policy, I may not be eligible for coverage if I am currently totally disabled.

I understand that if I am not applying for dependent coverage due to reasons other than my dependents having qualifying existing coverage there are two important consequences: In all states but Texas, the effective date of coverage may be delayed or **the period during which pre-existing conditions will not be covered may be extended** for my dependents, as described in the Late Applicant Eligibility, Effective Dates and Pre-Existing Conditions Limitations provision set forth in the Master Policy. As a result, I waive all claim benefits payable for my dependents. For Texas, the effective date of coverage will be delayed until the next Open Enrollment Period and the Late Applicant will be subject to a twelve (12) month Pre-Existing Condition Limitation Period. Further, I understand that for my dependents to have Life insurance coverage under this Plan in the future, I may be required to furnish satisfactory evidence of insurability at my expense, and all provisions applicable to a dependent will apply.

PERSONAL INFORMATION NOTICE

As required by law, this notice is intended to inform you that 1) Personal information may be collected from persons other than the individual applying for coverage; 2) Such information as well as other personal or privileged information collected by the Insurance Company or its legal representative may be in certain instances, as prescribed by law, disclosed to third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of insurance information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years beyond the date of my signature below; that while I may revoke it in writing at any time during that time period, any such revocation will not affect past reliance; that I may request a copy of this signed authorization; that my signing this authorization is voluntary and is not a condition for enrollment or processing of claims; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature X _____ Date _____