



The RIGHT Benefits. The RIGHT Price.



EMPLOYER MEMBERSHIP APPLICATION

INSTRUCTIONS FOR COMPLETION

Section 1 – Complete employer information

Section 2 – Answer all questions

Section 3 – Complete benefit selection

Section 4 – Employer must read certification and sign

Section 5 – Producer Information – complete information & sign

Case submission checklist – The following required items are enclosed:

- A COMPANY check for one month’s estimated premium \$ _____ made payable to Allied National, Inc. (Premiums payable by company check only.)
- Fully completed employee applications or fully completed waiver of coverage form(s).
- Copy of most recent state quarterly unemployment tax report (required on all cases submitted).
- Copy of proposal used to quote group benefits and rates.
- Copy of most recent billing and billing of 12 months ago from current insurance carrier for takeover verification (if applicable).

Medical Coverage: UNDERWRITTEN BY American Alternative Insurance Corp., Princeton, NJ
Life Coverage: UNDERWRITTEN BY Guarantee Trust Life Insurance Co., Glenview, IL

SECTION 1 – EMPLOYER NAME AND ADDRESS

If the plan sponsor permits independent contractors to participate in its health benefit plan, references to “employee”, “employer” and “employment” include independent contractors, the plan sponsor, and their independent contractor relationship. Use of such terms is solely for convenience and does not establish an employment relationship nor alter or waive the independent contractor status.

Firm name _____

Tax ID # _____

Location/street address _____

Mailing address (if different from location) _____

City _____ County _____ State _____ Zip _____

Telephone () _____ FAX () _____

E-mail _____

SECTION 3: PLAN SELECTION

ADMINISTRATOR'S USE ONLY	
CASE #	_____
POLICY #	_____
EFFECTIVE DATE	_____

Step One:

Indicate PPO Network Selection: _____

Step Two:

Indicate for which plan(s) you are applying:

- Cost Saver**
- Wellness Horizons® Major Medical Plans**
 - Premium Advantage Plan
 - HSA Qualified Plan (high deductible health plan)
 - Provider Freedom
 - HSA Provider Freedom
- CoreValue Health Plan**
 - Employer Pay
 - Voluntary
- Life Coverage**
- Check here if a combination of plans is being used in a multiple class or choice* offering.**

If offering benefits on a class* basis or as part of a multi-choice* offering, please indicate class/plan descriptions below.			
	Class Description (be distinct)	Medical Plan	Life Amount**
CLASS 1			
CLASS 2			
CLASS 3			
CLASS 4			
CLASS 5			

* Cost Saver can not be used on a multiple-choice offering (may be offered on class basis only). No more than five classes can be offered with a minimum of two participants in each class. (Call Allied for HSA exceptions.)

** If amounts differ, the higher amount cannot exceed 2.5 times the lowest amount.

Step Three:

Attach a copy of the proposal used to quote plan benefits and rates. This is critical. Final benefits and/or rates are subject to underwriting approval, but the sold quote provides the basis of your complete benefit choices.

SECTION 4 – CERTIFICATION & SIGNATURE

I/we hereby apply for participation in a group insurance program of Allied Group Insurance Trust, and agree to be bound by the terms of the trust agreement (a copy of which will be furnished to me upon my request) and to pay the monthly membership and administrative fee and a minimum of 25% of each employee's premium costs. I/we hereby also apply for membership in the Allied Employers Association. I/We appoint David W. Ashley, president of Allied Employers Association, as my/our proxy and authorize him in my/our absence at any meeting of members of Allied Employers Association, to cast any votes I/we would be entitled to cast if personally present, on any and all matters. Said proxy is to continue for a period of one (1) year from date and is hereby renewed from year to year until this proxy is cancelled by writing delivered to the Association.

I/we understand and agree that if, on the effective date, an employee is not in regular, full-time active work (or on approved medical leave if Guaranteed Issue Coverage), or (except for Guaranteed Issue Coverage) a dependent is confined in a hospital or institution, is disabled, is receiving Social Security disability benefits, or is unable to carry on the activities of a person of like age and sex in good health, coverage for such employee or dependent shall be deferred until such employee or dependent qualifies for coverage in accordance with the Master Policy provisions (i.e. the employee is actively at work or the dependent is not disabled, is not receiving Social Security disability benefits, and is able to carry on the activities of a person of like age and sex in good health) as set forth in the Master Policy.

I/we understand and agree that (1) All terms, provisions and benefits of the group insurance program shall be determined by the Master Policy issued to the Trust by American Alternative Insurance Corp.; (2) Participation in the group insurance program of the Trust, and membership in the Allied Employers Association, is subject to written approval of this application; (3) **No liability is created or assumed by the Insurance Company until this application has been approved in writing;** (4) If for any reason this application is not so approved in writing the sole obligation of the Insurance Company will be, and the employer shall be entitled to only, a refund of any monies paid; and (5) The agent or any other person(s) describing the Plan of group insurance has no authority to bind coverage or alter the terms of the Master Policy providing the benefits.

I/we understand that under the Outpatient Prescription Drug Card Benefit, I am/we are responsible for reimbursement for any benefits paid after termination of coverage for any insured and/or dependents.

I/we understand that my/our application and any coverage provided under the Master Policy is a part of my/our Employee Welfare Benefit Plan established for my/our employees, certain rights granted by the "Employee Retirement Income Security Act of 1974" (ERISA), the "Consolidated Omnibus Budget Reconciliation Act of 1985", the "Health Insurance Portability and Accountability Act of 1996", the Patient Protection and Affordable Care Act of 2010, and other federal and state law (Benefit Laws) may apply to all participants, and I/we retain all plan sponsor, plan administrator and plan fiduciary responsibilities under the Benefit Laws, and I/we remain responsible for compliance with the Benefit Laws including all mandatory notices to participants.

The pre-existing condition limitation provisions in the Master Policy have been explained and are understood by myself/ourselves and my/our employees. If a Cost Saver plan or option has been selected, the limited benefits of that coverage have been explained and are understood by myself/ourselves and my/our employees.

I/we understand and agree that I/we have delegated only those certain non-fiduciary, ministerial administrative acts, duties or responsibilities to Allied National, Inc. as stated herein.

Signed at _____
City & State

Signature _____

Name (Print) _____

Date _____

Title _____

Must be signed by Firm Owner, Partner or Officer

Final rates and eligibility for all groups is determined at the time of underwriting. DO NOT cancel current coverage until your new group coverage has been approved in writing by Allied.

SECTION 5 – PRODUCER'S INFORMATION

Producer's name _____

Allied agent number _____

Agency or company _____

Address _____

City _____ State _____ Zip _____

Telephone () _____ Fax () _____

Pay commissions to: Agent _____ Agency _____

Check here, if currently receiving commission and wish no change to be made.

SS # OR Tax I.D.# _____

Certificates of Insurance or Insurance ID Cards are routinely sent to you for delivery to your employer client within 48 hours of approval for insurance. Check here if you wish for this information to be sent directly to your client.

PRODUCER'S STATEMENT (Must be completed and signed)

I am now licensed with American Alternative Insurance Corp. in the state where this employer is located. Yes No

I hereby certify that all of the information contained in the Membership Application and employee enrollment forms is correct to the best of my knowledge, and I know of nothing adverse concerning this firm or of no adverse health conditions concerning any individual proposed for coverage other than as disclosed on such application and forms. I have complied with the underwriting rules and regulations and have explained in detail the coverage, to the new member firm and its employees.

In the event of rescission of insurance coverage for which I am agent, I hereby agree to reimburse Allied National, Inc., on behalf of the Insurance Company, for any and all Commissions paid on such rescinded insurance.

Date Completed _____ Signature of Producer _____

Distributor name and number: _____

RETURN APPLICATION TO: UNDERWRITING • ALLIED NATIONAL • 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.