



## Instructions

- Please check the box below that fits your rate requirement for this case.
- We have outlined the type of rate offering you will receive based on the information provided.

**INTRODUCTORY RATE** = Rate produced with minimum amount of medical information. This rate work up is **not** reviewed by a member of our Underwriting Risk Assessment Team. This is not a final rate and is subject to change.

**Requirements for an Introductory Rate:**

- Any carrier health application or health questionnaire on each applicant.
- Desired plan benefit design(s).
- Completion of the case information on next page.

**PROVISIONAL RATE** = Rate produced evaluated by a member of our Underwriting Risk Assessment Team. Any change in census or additional health information could change the rates. Participation and eligibility are not verified.

**Requirements for a Provisional Rate:**

- Allied Enrollment Form or other approved application with ERISA disclosure statement signed and dated by each employee (and spouse) applying for coverage.
- Permission to contact the employees and/or employer when deemed necessary to evaluate the medical risk presented. **Group is aware phone calls will be made.**
- Renewal rate information – If unable to provide, please provide explanation.

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- Desired plan benefit design(s).
  - Completion of the case information on next page.

**SIGNATURE RATE** = Medical rates determined by a member of our Underwriting Risk Assessment team. This is a complete case submission and allows underwriting to confirm participation, determine employee eligibility and perform a medical review of group. Rates issued are FINAL.

**Requirements needed to generate a final rate & bind coverage:**

- Allied Enrollment Form or other approved application with ERISA disclosure statement signed and dated by each employee (and spouse) applying for coverage. If not applying for coverage, please fully complete a waiver.
- Permission to contact the employees and/or employer when deemed necessary to evaluate the medical risk presented. **Group is aware phone calls will be made.**
- Current Carrier premium statement with renewal rates – if unable to provide please provide explanation.

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- Completed Plan Sponsor (Employer) Statement
  - Most recent State Quarterly Tax & Wage statement for groups of 25 employees or less.
  - Desired plan benefit design(s).
  - Completion of the case information on next page.

## Case Information

Company Name: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Nature of Business and SIC code \_\_\_\_\_

Company Contact: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

Number of full time employees \_\_\_\_\_ Number of Total Employees \_\_\_\_\_

Eligible for Cobra (please check)  Yes  No

Will there be an HRA or GAP plan in place?  Yes  No If yes, benefit amount \_\_\_\_\_

Permission to call employer and/or employee?  Yes  No

Special Instructions

## Overwrite Information

Overwrite Name & Allied GA Number: \_\_\_\_\_

Commission GA \_\_\_\_\_

Phone number \_\_\_\_\_

Email \_\_\_\_\_

Contact Person \_\_\_\_\_

Special Instructions

## Agent Information

Agent Name & Allied Agent Number \_\_\_\_\_

Commission Agent #1 \_\_\_\_\_

Commission Agent #2 \_\_\_\_\_

Phone number \_\_\_\_\_

Email \_\_\_\_\_

Contact Person \_\_\_\_\_

Special Instructions