ALLIED™ NATIONAL
A 90 Degree Benefits Company

Sales
Transmittal Form

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.***

☐ **NON UNDERWRITTEN 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.

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

☐ **FINAL 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. Any change in census or additional health, could change the rate.

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.
- 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.

Sales Support
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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
City, State, Zip:
Phone Number
Email
Contact Person
Special Instructions

Agent Information

Agent Name & Allied Agent Number
Commission Agent #1
City, State, Zip:
Commission Agent #2
City, State, Zip:
Phone Number
Email
Contact Person
Special Instructions