AGENT REQUEST FOR PROPOSAL

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

HOW TO SUBMIT A PROPOSAL REQUEST:

1. Fill out agent and client information in its entirety.
2. Indicate plan(s) you wish quoted and the benefits for each plan selected.
3. Provide complete census information as specified.
4. Mail, email or fax completed form to Allied National.
5. For questions, call Allied's Sales Support Team.

AGENT INFORMATION:

Agent Name _____ Agent # _____

Agency Name _____ Overwrite # _____

Phone # ( ) _____ Fax # ( ) _____ Email _____

CLIENT INFORMATION:

❑ Yes ❑ No — Is this a current client?

Name _____ SIC/Industry _____

Nature of Business _____

City _____ State _____ Zip _____ County _____

Requested Effective Date _____

Please Describe Any Subsidiaries, Other Locations or Benefit Class Descriptions _____

_____

_____

FUNDING ADVANTAGE QUOTE REQUESTS

Allied's guideline for a timely Funding Advantage new case submission is a minimum of 10 working days before the requested effective date. Typical underwriting can take up to three weeks depending on completeness of a submission and how quickly missing information is received. To be considered a submission, the employer information statement, current plan information (benefits, current and renewal rates), employee enrollment cards/waivers and participation documentation (on groups with less than 50 participants) is required. Submissions without these components are considered prescreen/quote requests only and not handled as a new case submission.

Please specify plan designs (PPO network, office visit copay, deductible, coinsurance, out of pocket, RX):

Plan 1: _____

_____

Plan 2: _____

_____

Plan 3: _____

_____

❑ **Yes** ❑ **No** — Are these plans offered as dual choice plans?

❑ **Yes** ❑ **No** — Are these plans offered with an underlying HRA? If so, what is the HRA deductible? _____

Please specify current plan designs (office visit copay, deductible, coinsurance, out of pocket, RX) and provide current/renewal rates:

Plan 1: _____

_____

Plan 2: _____

_____

PLAN OPTION:

❑ **$500 SUPPLEMENTAL ACCIDENT BENEFIT** — pays 100% of charges incurred by an accident up to a $500 benefit (not available on HSA qualified plans).

OTHER PLAN QUOTE REQUESTS

❑ **ALLIED™ DENTAL DESIGN** (Groups of 2-99)

Annual Benefit:	❑ $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		
Allied Vision	❑ Silver Plan	❑ Gold Plan	❑ Gold Materials Only

DD Quick Quotes
I _____ C _____
S _____ F _____

❑ **PIVOT SHORT TERM MEDICAL —** rated online at: *www.alliednational.com/pivotstm*

CENSUS INFORMATION SAMPLE – ALL PLANS

Please, whenever possible, send census information on a spreadsheet.

www.alliednational.com/forms_agent.htm has a link to Allied's census template

Employee Name (Optional)	DOB or Age	Gender	Coverage Type I-S-C-F	Owner, Officer, Partners Y/N (if requesting 24-hour coverage)	Benefits – Medical, Dental	Occ Class for Occupation Based Benefits

Coverage Type:
I = Insured
S = Insured and Spouse
C = Insured and Children
F = Insured, Spouse and Children

Owner, Officer, Partner Yes or No answer determines eligibility for Occupational Coverage option under Allied Health Plans.

PRESCREEN REQUESTS

Allied will review medical applications for prescreen rate estimates. Allied apps or other appropriate applications may be submitted. Priority is given to Allied apps. Please provide legible application copies. All prescreens are estimates subject to change at time of final underwriting. Current and renewal rates are required for prescreen requests.

GROUPS OF 100+ MAJOR MED EXPERIENCE UNDERWRITING REQUIREMENTS

Employer Coverage History (past three plan years if available)

- Insurance carrier or HMO name and dates of coverage.
- Schedule of benefits for each coverage period.
- Managed care network for each coverage period.

Employee Information

- Age/DOB, gender, family coverage, employer location.
- Must include all Cobra employees and retirees.
- Cobra employees and retirees must be indicated.

Rate history (past three plan years if available)

- If employer was fully insured, need premium rates.
- If employer was self insured, need to know specific deductible, contract type, specific & aggregate premium rates and aggregate factors.

Verified paid claims and enrollment — 24 to 36 months of experience

- If employer was fully insured, need paid claims and average enrollment by plan year and product.
- If employer was self insured, need monthly paid claims & enrollment by product.
- For new business, need 11 months of current year's experience.
- For renewals, need 10 months of current year's experience.

Large Claims Information (Shock loss)

- Claims which have reached $20,000 or that have exceeded 50% of the proposed specific deductible.
- Claims expected to $20,000.
- Information should include at least the following:
  - Dates of treatment/Service
  - Payment Dates & Amounts
  - Past, present & future treatment
  - Diagnosis & prognosis
  - Claimant status (active, retired, or COBRA)
  - Employee or dependent

Dual Choice Plans

When experience is based on a dual choice plan, please note the additional requirements:

- Minimum — enrollment counts by current plan (# single employees, spouses and children for each plan).
- Preferred — census showing current enrollment.
- Optimal — experience by plan.

Send Quote Requests To Allied National
By Email: sales@alliednational.com
By Fax: 913-945-4396
By Mail: P.O. Box 29189, Shawnee Mission, KS 66201-9189
For Assistance Contact Sales Support: 888-767-7133 Local: 913-945-4100