
ACKNOWLEDGMENT

(may be photocopied or duplicated)

ACKNOWLEDGMENT OF LIMITED BENEFITS

I have requested to sponsor an employer's group health plan ("Employer Plan") and hereby acknowledge:

- Coverage under the Employer Plan will be LIMITED to those benefits available under Allied™ Cost Saver.
- Allied™ Cost Saver is not "catastrophic" major medical coverage.
- Allied™ Cost Saver is supplemental group health insurance, designed to supplement and coordinate with high deductible "catastrophic" coverage.
- Benefits under Allied™ Cost Saver have specific Calendar Year Benefit limits as outlined in the plan brochure and Certificate of Insurance.

Name of Employer: _____

Name of Employer Representative: _____

Signature of Employer Representative: _____

Date: _____

Employer ID Number: _____