

## EMPLOYER STATEMENT

### INSTRUCTIONS FOR COMPLETION

Section 1 – Complete employer information

Section 2 – Answer all questions

Section 3 – Complete plan selection

Section 4 – Employer must read and sign

Section 5 – Producer Information – complete & sign

**Case submission checklist - The following required items are enclosed:**

- A company check for the first month's estimated total cost made payable to Allied National, Inc.
- Fully completed Employer Statement.
- Fully completed enrollment form or waiver on every eligible employee.
- Copy of most recent state quarterly unemployment tax report.
- Copy of proposal showing selected benefits and total monthly cost.
- Copy of most recent billing.
- Copy of current renewal notice.

### SECTION 1 – EMPLOYER NAME AND ADDRESS

If the Employer (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.

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

Tax ID # \_\_\_\_\_

Location/Street Address \_\_\_\_\_

Mailing address (if different from location) \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (     ) \_\_\_\_\_ FAX (     ) \_\_\_\_\_

Email \_\_\_\_\_



## SECTION 3: PLAN SELECTION

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

Indicate which plan(s) you are selecting:

- Premium Advantage PPO Plan

Indicate PPO Network Selection: \_\_\_\_\_

- HSA Qualified Plan (high deductible health plan)

Indicate PPO Network Selection: \_\_\_\_\_

- Indemnity Freedom (no PPO network, use any provider)

- Check here if multiple benefit plans are being used in a dual choice offering.

**Attach a copy of the proposal** to document selected ERISA plan benefits. Plan eligibility, benefit plan and monthly costs are subject to underwriting.

## SECTION 4 – CERTIFICATION & SIGNATURE

I/we understand that the stop loss insurance being requested in conjunction with our health benefit plan: (1) is subject to written approval and **no liability is created or assumed by the insurance company issuing the stop loss coverage until application has been approved in writing**; (2) If for any reason the application for stop loss insurance is not approved the sole obligation of the insurance company will be, and the plan sponsor shall be entitled to only, a refund of any monies paid; (3) the stop loss coverage is based on the current Summary Plan Description and any change to that description, or any benefit payment made that is not consistent with that description, may not be covered by the stop loss coverage; (4) coverage for any individual plan participant must be approved by the stop loss carrier before benefit payments are eligible under the stop loss coverage and (5) the agent or any other person(s) describing and soliciting the purchase of the stop loss insurance has no authority to bind coverage or alter the terms of the stop loss insurance.

I/we understand that I/we are responsible for reimbursing the stop loss insurance carrier for any medical expenses incurred, including under the Outpatient Prescription Drug Card Benefit, that are not eligible under the stop loss insurance and for funds advanced by the stop loss insurance carrier under the accommodation provision of the stop loss coverage.

I/we understand that all benefits provided under the Summary Plan Description are 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.

I/we engage the producer shown below as our medical benefit plan consultant to assist in the establishment of our medical benefit plan, to secure administrative services for the benefit plan and to secure stop loss insurance coverage for us. I/we acknowledge the consultant will receive a portion of the Sales and Administration fee charged by Allied National, Inc. (Allied)

I/we will engage Allied, via a separate administrative services agreement, to act as the third party administrator (TPA) for our medical benefit plan and delegate certain non-fiduciary, ministerial administrative acts, duties or responsibilities to Allied as stated herein ("Delegated Services"), that such delegation is a separate business arrangement between the employer and Allied, that the Delegated Services are not part of the stop loss insurance purchased by the employer, that none of the premium charged for the stop loss insurance pays for or is allocated to the Delegated Services, and that fees charged for the Delegated Services are not part of the stop loss insurance premium but are a separate charge. Delegated Services include, but are not limited to:

- Tracking employee and dependent enrollment in the medical benefit plan;
- Bill, collect, hold and disburse funds from which to pay claims and stop loss insurance premiums;
- Provide utilization review services for inpatient admissions, maternities and certain outpatient services;
- Process provider claims to determine and pay benefits as provided for under the medical benefit plan;
- Bill, collect and remit agent consulting fees; and

- Arranging access to, billing and remitting fees for discounted fee arrangements (including managed care and pharmacy networks) and wellness programs (or similar employee support programs).

I/we agree that Allied will hold funds we advance to cover benefits under the plan in trust in an interest bearing account with similar funds from other employers and that the interest earned is retained by Allied as part of its compensation for administrative services. I/we agree that benefits will be issued from an account under the name of the stop loss insurance company using funds provided by the employer, funds advanced to the employer by the stop loss insurance company under the stop loss insurance accommodation provision and by funds from the carrier for claims eligible for reimbursement by the stop loss insurance policy. I/we agree that if the stop loss coverage is not approved Allied will decline to provide administrative services to the employer.

Signed at \_\_\_\_\_  
City & State

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name (Print) \_\_\_\_\_

Title \_\_\_\_\_

Must be signed by Firm Owner, Partner or Officer

**Final monthly costs and eligibility is determined at the time of underwriting. DO NOT cancel current coverage until written notice of approval of stop loss coverage has been received from Allied.**

## SECTION 5 – PRODUCER’S INFORMATION

Producer’s Name \_\_\_\_\_ Allied Agent # \_\_\_\_\_

Agency or Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (     ) \_\_\_\_\_ Fax (     ) \_\_\_\_\_

Social Security Number or TIN \_\_\_\_\_ Email Address \_\_\_\_\_

Pay service fees to:  Agent \_\_\_\_\_  Agency \_\_\_\_\_

### DELIVERY OF PLAN MATERIALS

Plan materials, including ID Cards, are routinely sent to you for delivery to your client.

Check here if you wish for plan materials to be sent directly to your client.

### PRODUCER’S STATEMENT

I am now appointed 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 this Employer Statement and in the employee enrollment forms is correct to the best of my knowledge, and I know of no adverse information concerning this firm or any individual’s health status other than as disclosed. I have complied with the underwriting rules and regulations and have explained in detail the benefit plan and stop loss coverage to the employer.

I hereby acknowledge the service fees paid to me by the employer will be billed and collected on my behalf by Allied National and that those fees are based on the actual enrollment in any month.

Date Completed \_\_\_\_\_ Signature of Producer \_\_\_\_\_

Distributor name and number: \_\_\_\_\_

**RETURN TO: UNDERWRITING • ALLIED NATIONAL • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187**  
 Electronic copies of this form submitted via facsimile, email or other electronic means shall be deemed an original.