ALLIED® National Companies

Horizons® Health Plans

EMPLOYER MEMBERSHIP APPLICATION

INSTRUCTIONS FOR COMPLETION

Section 1 – Complete Employer information

Section 2 – Answer all questions

Section 3 – Complete Benefit Selection

Section 4 – Employer must read certification and sign

Section 5 – Producer Information – Complete information & sign

CASE SUBMISSION CHECKLIST: The following required items are enclosed:

- ❒ **A COMPANY check for one month's estimated premium $ _____ made payable to Allied National, Inc. (Premiums payable by Company check only.)**
- ❒ **Fully completed Employee Applications or fully completed Waiver of Coverage form(s).**
- ❒ **Copy of most recent state quarterly unemployment tax report** (required on all cases submitted).
- ❒ **Copy of proposal used to quote group benefits and rates.**
- ❒ **Copy of most recent billing and billing of 12 months ago from current insurance carrier for takeover verification (if applicable).**

UNDERWRITTEN BY GUARANTEE TRUST LIFE INSURANCE COMPANY, GLENVIEW, IL

SECTION 1 – EMPLOYER NAME AND ADDRESS

FIRM NAME _____

LOCATION/STREET ADDRESS_____

MAILING ADDRESS (if different from location)_____

CITY _____ COUNTY_____ STATE _____ ZIP _____

TELEPHONE ( ) _____ FAX ( ) _____

E-Mail _____

SECTION 2 – EMPLOYER INFORMATION

1. Firm is a: Sole Proprietorship ❑ Partnership or L.L.C. ❑ Corporation ❑
2. Specific nature of firm's business _____ SIC Code _____
3. Are any affiliated or subsidiary companies to be insured under this plan? ❑ YES ❑ NO
   If "YES", please provide name, address and percent of ownership of the affiliate or subsidiary company:
   _____
4. Name of person at applicant's firm handling insurance details _____
5. Does this firm have a group insurance plan in-force now or has it had one in-force within the past 90 days? ❑ YES ❑ NO

   If "YES", please provide the: 1) effective date of plan _____and

   2) paid-to date or term date for this plan _____

   If "YES", we need verification of effective dates with the prior carrier. This can be accomplished by providing us with a copy of your most recent premium billing from your current carrier and also a copy of your premium billing from 12 months ago. This allows us to provide the proper credits for coverage under a prior plan.
6. A. I hereby certify that there are, as of this date a total of _____ full-time (30 hours per week; 24 hours per week in Oklahoma only; 25 hours per week in Ohio only) eligible employees (including owner(s), partners, and officers) in the employment of this firm.

   B. I further certify that on an average business day in the preceding calendar year the firm employed ____ employees (including full-time, part-time, temporary, seasonal and union employees).

   C. I hereby certify that this firm began active business on (month) _____(year)_____

   D. Does this firm have any former employees on COBRA continuation of coverage? ❑ YES ❑ NO

   If YES, how many?_____
7. If any class or classes of employees are to be excluded from eligibility describe them briefly. All class exclusions must be pre-approved by Administrator before application. All class exclusions must be non-discriminatory.
   _____
8. I understand and agree that investigation(s) may be made now and in the future, by or on behalf of the Administrator to verify the number and names of full-time, eligible employees of this firm, and will furnish, upon request, a current census and most recent state unemployment tax report prior to each anniversary date.
9. I understand and agree that the following eligibility rules will apply to all employees of this firm:

   A. **ALL** employees hired on or before the firm's effective date of insurance are eligible following completion of

   ❑ 0 months ❑ 1 month ❑ 2 months ❑ 3 months of active full-time service.

   B. **ALL FUTURE** employees shall become eligible on the first day of the month coinciding with or next following the completion of:

   ❑ 1 month ❑ 2 months ❑ 3 months of active full-time service.

   Applications must be received by the Administrator prior to the date the employee becomes eligible.
10. I understand and agree that:

    A. A minimum of two (2) employees' participation is required at all times. Failure to maintain this minimum participation requirement will result in termination of all coverage at the end of one (1) month if participation is not re-established.

    B. Failure to maintain 75% employee participation and 50% dependent participation will result in termination of all coverage at the end of three (3) months if participation is not re-established and maintained for 3 consecutive months.
11. Requested effective date is_____ . Coverage may be any day of the month. Billing and renewals will be on the first of the month thereafter. All papers must be signed and dated on or before the requested effective date and be received by the Administrator within 5 working days beginning with such date in complete and acceptable form or the requested date may not be granted.

Please complete information and sign on back page.

SECTION 3: BENEFIT SELECTION

Choose Horizons Cost Saver Plan, Horizons Cost Saver Plus Major Medical Plan or a Horizons Major Medical Plan and the benefits for each you are applying for.

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

Step One:
Indicate PPO Network Selection:_____

Step Two: Indicate for which plan(s) you are applying:

❑ **Horizons® Cost Saver**

❑ Bronze ❑ Silver ❑ Gold

Life Coverage: ❑ None ❑ $10,000 (Not available as a life only option)

❑ **Horizons® Cost Saver PLUS Major Medical**

Horizons Cost Saver Level	Out-of-Pocket Maximum
❑ Bronze	❑ $5,000
❑ Silver	❑ $7,500
❑ Gold	❑ $10,000

❑ **Horizons® Major Medical Plans**

- ❑ HSA High Deductible Health Plan
- ❑ Premium Advantage Plan
- ❑ Traditional PPO Plan
- ❑ No Deductible PPO Plan (not available in Texas)

❑ **Check here if a combination of plans is being used in a multiple class or choice* offering.**

If offering benefits on a class* basis or as part of a multi-choice* offering, please indicate class/plan descriptions below.			
	Class Description (be distinct)	Medical Plan	Life Amount**
CLASS 1			
CLASS 2			
CLASS 3			
CLASS 4			
CLASS 5			

.*Horizons Cost Saver can not be used on a multiple-choice offering (may be offered on class basis only). No more than five classes can be offered with a minimum of two participants in each class. (Call Allied for HSA exceptions.)

**If amounts differ, the higher amount cannot exceed 2.5 times the lowest amount.

Step Three: Attach a copy of the proposal used to quote plan benefits and rates. This is critical. Final benefits and/or rates are subject to underwriting approval, but the sold quote provides the basis of your complete benefit choices.

Please complete information and sign on reverse.

SECTION 4 – CERTIFICATION & SIGNATURE

I/we hereby apply for participation in a group insurance program of Allied Group Insurance Trust, a Multiple Employer Trust, and agree to be bound by the terms of the trust agreement (a copy of which will be furnished to me upon my request) and to pay the monthly administrative billing charge and a minimum of 25% of each employee's premium costs. I/we hereby also apply for membership in the Allied Employers Association and agree to pay the annual membership fee. I/We appoint David W. Ashley, president of Allied Employers Association, as my/our proxy and authorize him in my/our absence at any meeting of members of Allied Employers Association, to cast any votes I/we would be entitled to cast if personally present, on any and all matters. Said proxy is to continue for a period of one (1) year from date and is hereby renewed from year to year until this proxy is cancelled by writing delivered to the Association.

I/we understand and agree that if, on the effective date, an employee is not in regular, full-time active work (or on approved medical leave if Guaranteed Issue Coverage), or (except for Guaranteed Issue Coverage) a dependent is confined in a hospital or institution, is disabled, is receiving Social Security disability benefits, or is unable to carry on the activities of a person of like age and sex in good health, coverage for such employee or dependent shall be deferred until such employee or dependent qualifies for coverage in accordance with the Master Policy provisions (i.e. the employee is actively at work or the dependent is not disabled, is not receiving Social Security disability benefits, and is able to carry on the activities of a person of like age and sex in good health) as set forth in the Master Policy.

I/we understand and agree that (1) All terms, provisions and benefits of the group insurance program shall be determined by the Master Policy issued to the Trust by Guarantee Trust Life Insurance Company; (2) Participation in the group insurance program of the Trust, and membership in the Allied Employers Association, is subject to written approval of this application; **(3) No liability is created or assumed by the Insurance Company until this application has been approved in writing;** (4) If for any reason this application is not so approved in writing the sole obligation of the Insurance Company will be, and the employer shall be entitled to only, a refund of any monies paid; and (5) The agent or any other person(s) describing the Plan of group insurance has no authority to bind coverage or alter the terms of the Master Policy providing the benefits.

I/we understand that under the Outpatient Prescription Drug Card Benefit, I am/we are responsible for reimbursement for any benefits paid after termination of coverage for any insured and/or dependents.

I/we understand that my/our application and any coverage provided under the Master Policy is 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) apply to all participants, and I/we retain all plan sponsor, plan administrator and plan fiduciary responsibilities under ERISA.

The pre-existing condition limitation provisions in the Master Policy have been explained and are understood by myself/ourselves and my/our employees. If a Cost Saver plan or option has been selected, the limited benefits of that coverage have been explained and are understood by myself/ourselves and my/our employees.

I/we understand and agree that I/we have delegated certain non-fiduciary, ministerial administrative acts, duties or responsibilities to Allied National, Inc., and that Allied's fee for this service is included in the premium or as a separate fee.

Signed at _____ Signature _____

City & State

Name (Print)_____

Date _____ Title_____

Must be signed by Firm Owner, Partner or Officer

Final rates and eligibility for all groups is determined at the time of underwriting. DO NOT cancel current coverage until your new group coverage has been approved in writing by Allied.

SECTION 5 – PRODUCER'S INFORMATION

PRODUCER'S NAME _____

ALLIED AGENT NUMBER_____

AGENCY OR COMPANY _____

ADDRESS _____

CITY_____ STATE _____ ZIP _____

TEL. ( )_____ FAX ( ) _____

PAY COMMISSIONS TO_____ SS # OR TAX I.D.# _____

PRODUCER'S STATEMENT (Must be completed and signed)

I am now licensed with Guarantee Trust Life Insurance Company in the state where this employer is located. ❑ Yes ❑ No

I hereby certify that all of the information contained in the Membership Application and employee enrollment forms is correct to the best of my knowledge, and I know of nothing adverse concerning this firm or of no adverse health conditions concerning any individual proposed for coverage other than as disclosed on such application and forms. I have complied with the underwriting rules and regulations and have explained in detail the coverage, to the new member firm and its employees.

In the event of rescission of insurance coverage for which I am agent, I hereby agree to reimburse Allied National, Inc., on behalf of the Insurance Company, for any and all Commissions paid on such rescinded insurance.

Date Completed _____ Signature of Producer_____

MAIL TO:
ALLIED NATIONAL
UNDERWRITING DEPARTMENT
P.O. BOX 419254
KANSAS CITY, MO 64141-6254

DIST. NAME & NUMBER