AST Risk

Underwriting Transmittal Form

Thank you for allowing AST Risk to review your group. We have outlined the type of rate offering your will receive based on the information provided. Please check the box below that fits your rate requirement needs for this case.

☐ **Introductory Rate** = Medical rate produced with minimum amount of medical information. 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 person interested in coverage.
- Completion of the case information on next page.
- Desired plan design(s).

☐ **Preliminary Rate** = Medical rate produced is evaluated by a member of our Underwriting Risk Assessor Team. Any change in census or additional health information could change the rates. Participation and eligibility are not verified.

Requirements for a Provisional Rate:

- Approved applications by AST Risk or ERISA disclosure form which is signed and dated by each employee applying for coverage if **NOT** using AST Risk approved applications.
- Renewal rate information – if unable to provide, please provide explanation: _____

  _____
- 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.**
- Desired plan design.
- Completion of the case information on next page.

☐ **Final Rate** = Medical rates are determined by a member of our Underwriting Risk Assessor team. This allows underwriting to complete participation, eligibility of employees and medical review of the group.

Requirements needed to generate a final rate & bind coverage:

- Completed case information on next page.
- Approved applications by AST Risk or waivers if not enrolling for coverage. Or ERISA disclosure form signed and dated by each employee for groups **NOT** using AST Risk approved applications.
- Most recent State Quarterly Tax & Wage statement for groups enrolling 25 employees or less.
- Current Carrier premium statement with renewal rates – if unable to provide, please provide explanation: _____

  _____
- **Group is aware phone calls will be made.**

Case Information

Company Name: _____ Tax ID Number: _____

Person to Contact: _____ Email: _____

Street address: _____

City, State, Zip: _____

Owner/Officer: _____ Email: _____

Subsidiaries/Affiliated Companies _____ Tax ID Number: _____

Street address: _____ City, State, Zip: _____

Nature of Business and SIC code: _____

Phone number: _____ Email: _____

Requested Effective Date: _____ Group/Comp Number: _____

Number of full-time employees: _____ Number of Total Employees: _____

Eligible for Cobra (please check box) ❑ Yes ❑ No

Will there be an HRA or GAP plan in place? ❑ Yes ❑ No

Permission to call employer & employees? ❑ Yes ❑ No

Special Instructions:

Agent Information

Agent Name: _____

Agency Address: _____

Agent Email: _____

Agent Phone: _____

Agent License Number: _____ Tax ID Number: _____

Special Instructions:

TPA Information

TPA Name: _____ Tax ID Number _____

Person to Contact: _____ Email: _____

Street address: _____

Phone number: _____ Email: _____

Special Instructions:

Underwriting Department
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