THE ALLIANCE
Employers moving health care forward

NEW GROUP SET-UP FORM

Please return this completed form 15 days prior to the effective date to:
newmembers@the-alliance.org | FAX: 608.276.6626

Interactive PDF

Member (Employer) Information

Company Name:		Effective Date:
Local Address:		Accessing Employees #:
City, St, Zip:		Total Employees #:
Federal ID/EIN:		Renewal Month:

Member Contact Information

Primary Contact:		
Job Title:		
Email Address:		
Phone Number:		Ext:
FAX Number:		
Preferred Mailing:		
City, St, Zip:		
Executive Name:		
Job Title:		
Is this person local?	☐ YES	☐ NO
Is member a subsidiary, organized under a parent company?	☐ YES	☐ NO
Parent Company:		
Parent Location:		
Are benefit decisions made locally?	YES	NO

Agent Information

Agency:		
Name:		
Job Title:		
Email Address:		
Agency Address:		
City, St, Zip:		
Phone Number:		Ext:
FAX Number:		
Account Manager:		
Email Address:		
Prior Carrier:		Since:
Was Member Previously:	☐ Self-Funded	☐ Fully-Insured

Please be sure all TPA, Invoicing & Plan Info is completed on the reverse side >

TPA Information

TPA Name:		
TPA Account Rep:		
Email Address:		
Phone Number:		Ext:
FAX Number:		
TPA Business Address:		
City, St, Zip		
Claims Submission Address:		
Toll-Free Ph# for Insured:		
Toll-Free Ph# for Providers:		

Subgroup/Divisions for Invoicing or Reporting

Does the member want subgroups for invoicing/reporting? ◯ YES ◯ NO

List any known subgroups, if applicable (divisions, locations, or other enrollee classifications). If necessary, please e-mail a complete list to The Alliance.

Division/Location:	Group Number:

Invoicing Instructions

Monthly Access Fees:	☐ TPA	☐ Employer	☐ Other	Contact Name:	
Invoice Email:				C/C Email To (optional):	
Monthly Retainage Fees:	☐ TPA	☐ Employer	☐ Other	Contact Name:	
Invoice Email:				C/C Email To (optional):	
Initial Membership/Stock:	☐ TPA	☐ Employer	☐ Other	Contact Name:	
Invoice Email:				C/C Email To (optional):	

Ancillary Services

Rx Manager:	Dental Carrier:	Vision Carrier:
Workers' Comp:	Reinsurance/Stop-Loss Carrier:	Wrap Network:

Please Provide the Following

Is there a specialty care network in place?	☐ YES	☐ NO	Name/Type:	
What is your Timely Filing Limit for claims?	☐ 12 months	☐ OTHER:		
What is the length/term of the stop loss contract?	☐ 12/15	☐ 12/12	OTHER:	

Please submit the member SUMMARY PLAN DESCRIPTION > ☐ Check here to agree the SPD & SBC will be sent to The Alliance