Thank you for allowing AST Risk to review your group. We have outlined the type of rate offering you 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).

☐ **Provisional 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 final enrollment card 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.

☐ **Signature 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 final enrollment card signed and dated by each employee for groups **NOT** using AST Risk approved applications.
- Most recent State Quarterly Tax & Wage statement for groups of 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 and DBA, if applicable: _____

Company Tax Identification Number: _____

Company Owner(s): _____

Person to Contact: _____

Company Address: _____

Nature of Business and SIC code: _____

Phone number: _____ Email: _____

Requested Effective Date: _____

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

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

If eligible for Cobra, are there any employees on COBRA on your Prior Carrier? ☐ Yes ☐ No

Is your Company a subsidiary of or affiliated with another business entity? ☐ Yes ☐ No

Does Company have any employees hired within the past three months? ☐ Yes ☐ No

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

Permission to call employer and employees? ☐ Yes ☐ No

Monthly premium payments setup on automatic withdrawal each month (done on the 10th of each month)? ☐ Yes ☐ No

Waiting period selection for:

Employees hired on or before the effective date? ☐ 0 months ☐ 1 month ☐ 2 months

Employees hired after the effective date? ☐ 1 month ☐ 2 months

Special Instructions

_____

_____

_____

_____

_____

_____

Agent Information

Agency Name: _____

Agent Name: _____

Agency Address: _____

City: _____ State: _____ Zip: _____

Tax Identification Number or SSN: _____

Phone number: _____ Email: _____

Contact Person: _____

Agent compensation : _____

Employee ID Card Kits mailed to: ☐ Agent ☐ Group

Overwrite Information

Overwrite Name: _____

Agency Address: _____

City: _____ State: _____ Zip: _____

Tax Identification Number or SSN: _____

Phone number: _____ Email: _____

Contact Person: _____

GA compensation : _____

Underwriting Department
P.O. Box 29187 • Shawnee Mission, KS 66201-9187 • 913-945-4100 • 800-825-7531
Fax: 913-945-4397 • astnewbusiness@alliednational.com