Allegiance℠
Life & Health Insurance Company

EMPLOYER APPLICATION FOR GROUP HEALTH INSURANCE

Section 1: Employer Information			
Legal Company Name	Nature of Business		
Owner's Name	Contact Person		
Contact Person's Email	Phone Number	Fax Number	
Company's Web Address (*if applicable)*			
Physical Address			
Mailing Address	City	State	Zip
Is Your Company Registered with the Montana Secretary of State? ❑ Yes ❑ No	Employer Tax ID#		
List any affiliates or businesses under this employer's common control if applicable.			
Do any employees live out of the state of Montana? ❑ Yes ❑ No If Yes, where are they located?	Zip Code(s)		

Section 2: Participation
1. What is the employer contribution toward employee premium? **(minimum of 50% is required**) _____
2. What, if any, is the employer contribution toward dependent premium? _____
3. Is there a different criterion by class of employee? ❑ Yes ❑ No If **YES,** identify what constitutes a class and how contribution is determined.
4. What are the minimum hours worked weekly to be eligible for coverage? _____
5. What is the Waiting Period* for new employees? (*To satisfy the Waiting Period(s), an eligible employee must be employed by the employer and actively at work for the number of hours per month required for eligibility, without break in active employment, for the entire Waiting Period.) **First day of the month following**: ❑ Employee's Hire Date ❑30 days ❑59 days

Note: If the Employer pays 100% of the Employee premium, all eligible employees (100% of eligible employees) must be covered, except those who have waived coverage as a result of other health coverage or for qualified religious reasons. If the Employer pays less than 100% of the Employee premium, 75% of eligible employees must be covered.
*An **eligible employee** is one who meets the minimum hourly requirements, and has satisfied the waiting period set by the employer as stated above. Those **not** meeting requirements are considered **not eligible.**

6. What is the total number of employees (both eligible and not eligible) as of effective date of the coverage? _____

7. How many are **eligible** for coverage under this policy? (This includes employees who have waived coverage) _____

Section 3: Employer Statement

As the employer or the legally authorized representative of the employer, I certify that all information provided for coverage by Allegiance Life & Health Insurance Company, Inc. is accurate and complete to the best of my knowledge.

Signed by Employer/Employer's Authorized Representative

Print Name	Title	Date

Section 4: Agent Statement

I certify that all of the information contained in this Employer Application and attached paper(s) is (are) correct to the best of my knowledge. I have complied with all of the submission rules and have explained the coverage fully and informed the group to submit all changes in writing to Allegiance Life & Health Insurance Company, Inc.

Agency Name	Agent's Signature	
Date	Print Name	
Address	City/State	Zip
Phone	Email	

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Broker Quote Request

(Refer to page 6 for available Deductible & OOP combinations)

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR A COMPLETE AL&H QUOTE

Attach an EXCEL census of all ELIGIBLE Employees (Name, DOB, Zip Code, and coverage code - EE, ES, EC, EF, WC, or WOC (Other Coverage)

1. Group Name		**Monthly Premiums**	
2. Current Carrier		**Current Rates**	**Renewal Rates**
If Age Rated, what is the Monthly Total - $		**EE**	**EE**
3. Requested Effective Date		**ES**	**ES**
4. Quote Due Date		**EC**	**EC**
5. Commissions ❑ Standard 5% ❑ Other		**EF**	**EF**
6. SIC Code (if available)			
7. Benefit Period – *if one is not selected plan year will be the option quoted*.	**❑ Plan Year (e.g. June-July)**	**❑ Calendar Year (Jan-Dec) If Calendar year – is deductible credit requested? ❑ Yes ❑ No**	
8. Dual Option ❑ Yes ❑ No			

9. Plan options may be *either* a PPO plan *or* a HDHP/HSA option. There will be 6 initial plans quoted, please indicate up to 6 plans.
Use the columns as your guide to the benefits that are available for both the PPO and HDHP/HSA plans.

Benefit Description	Plan Options 1 & 2		Plan Options 3 & 4		Plan Options 5 & 6	
	PPO	**HDHP/HSA**	**PPO**	**HDHP/HSA**	**PPO**	**HDHP/HSA**
Deductible per Insured. PPO Deductible does not apply toward Non-PPO Deductible. Non-PPO Deductible does not apply toward PPO Deductible	❑ $200 - (schools only) ❑ $500 ❑ $750 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $3,000 ❑ $5,000	❑ $1,300/$2,600 ❑ $2,000/$4,000 ❑ $2,600/$5,200 ❑$3,000/$6,000 ❑$3,500/$7,000 ❑$4,000/$8,000 ❑$5,000/$10,000 ❑$6,450/$12,900	❑ $200 -(schools only) ❑ $500 ❑ $750 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $3,000 ❑ $5,000	❑ $1,300/$2,600 ❑ $2,000/$4,000 ❑ $2,600/$5,200 ❑$3,000/$6,000 ❑$3,500/$7,000 ❑$4,000/$8,000 ❑$5,000/$10,000 ❑$6,450/$12,900	❑ $200 - (schools only) ❑ $500 ❑ $750 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $3,000 ❑ $5,000	❑ $1,300/$2,600 ❑ $2,000/$4,000 ❑ $2,600/$5,200 ❑$3,000/$6,000 ❑$3,500/$7,000 ❑$4,000/$8,000 ❑$5,000/$10,000 ❑$6,450/$12,900
Deductible per covered family. PPO Deductible does not apply toward Non-PPO Deductible. Non-PPO Deductible does not apply toward PPO Deductible	2x the deductible per Insured.	❑ Traditional – Benefits payable after Single deductible is met (embedded) ❑HDHP-Benefits payable after Individual *Deductible* is met for Employee only coverage. Benefits payable after Family *Deductible* is met for Family Coverage. (non-embedded)	2x the deductible per Insured.	❑ Traditional – Benefits payable after Single deductible is met (embedded) ❑ HDHP-Benefits payable after Individual *Deductible* is met for Employee only coverage. Benefits payable after Family *Deductible* is met for Family Coverage. (non-embedded)	2x the deductible per Insured.	❑ Traditional – Benefits payable after Single deductible is met (embedded) ❑ HDHP-Benefits payable after Individual *Deductible* is met for Employee only coverage. Benefits payable after Family *Deductible* is met for Family Coverage. (non-embedded)

Group Name:	Plan Options 1 & 2 cont…		Plan Options 3 & 4 cont…		Plan Options 5 & 6 cont…	
Medical Out-of-Pocket Maximum. PPO Out-of-Pocket Maximum does not apply toward Non-PPO Out-of-Pocket Maximum. Non-PPO Out-of-Pocket Maximum does not apply toward PPO Out-of-Pocket Maximum. Includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Annual Deductible or Medical Out-of-Pocket Maximum.	❑ $1,200 ❑ $1,500 ❑ $2,000 ❑ $2,250 ❑ $2,500 ❑ $2,750 ❑ $3,000 ❑ $3,500 ❑ $3,750 ❑ $4,000 ❑ $5,000	❑ N/A –plan pays upon satisfaction of deductible ❑ $2,600/$5,200 ❑ $3,000/$6,000 ❑ $3,500/$7,000 ❑ $4,000/$8,000 ❑ $5,000/$10,000 ❑ $5,200/$10,400 ❑$6,450/$12,900	❑ $1,200 ❑ $1,500 ❑ $2,000 ❑ $2,250 ❑ $2,500 ❑ $2,750 ❑ $3,000 ❑ $3,500 ❑ $3,750 ❑ $4,000 ❑ $5,000	❑ N/A –plan pays upon satisfaction of deductible ❑ $2,600/$5,200 ❑ $3,000/$6,000 ❑ $3,500/$7,000 ❑ $4,000/$8,000 ❑ $5,000/$10,000 ❑ $5,200/$10,400 ❑$6,450/$12,900	❑ $1,200 ❑ $1,500 ❑ $2,000 ❑ $2,250 ❑ $2,500 ❑ $2,750 ❑ $3,000 ❑ $3,500 ❑ $3,750 ❑ $4,000 ❑ $5,000	❑ N/A –plan pays upon satisfaction of deductible ❑ $2,600/$5,200 ❑ $3,000/$6,000 ❑ $3,500/$7,000 ❑ $4,000/$8,000 ❑ $5,000/$10,000 ❑ $5,200/$10,400 ❑$6,450/$12,900
Pharmacy Out-of-Pocket Maximum. Pharmacy Copayments serve to satisfy the Pharmacy Annual Deductible and Pharmacy Out-of-Pocket Maximum. Does not include the Medical Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage.	$1,600	N/A	$1,600	N/A	$1,600	N/A
Total Out-of-Pocket Maximum.	Medical Out-of-Pocket Maximum plus Pharmacy Out-of-Pocket Maximum.	Same as Medical Out-of-Pocket Maximum	Medical Out-of-Pocket Maximum plus Pharmacy Out-of-Pocket Maximum.	Same as Medical Out-of-Pocket Maximum	Medical Out-of-Pocket Maximum plus Pharmacy Out-of-Pocket Maximum.	Same as Medical Out-of-Pocket Maximum
Out-of-Pocket Maximum per covered family.	2x the Medical Out-of-Pocket Maximum per Insured plus 2x the Pharmacy Out-of-Pocket Maximum per Insured.	❑ Traditional ❑ HDHP	2x the Medical Out-of-Pocket Maximum per Insured plus 2x the Pharmacy Out-of-Pocket Maximum per Insured.	❑ Traditional ❑ HDHP	2x the Medical Out-of-Pocket Maximum per Insured plus 2x the Pharmacy Out-of-Pocket Maximum per Insured.	❑ Traditional ❑ HDHP

Group Name:	Plan Options 1 & 2 cont…		Plan Options 3 & 4 cont…		Plan Options 5 & 6 cont…	
Co-pay for *Provider* office visit.	❑ N/A ❑ $30– available only with the 80% Benefit Percentage option. ❑ $40– available with all Benefit Percentage options.	N/A	❑ N/A ❑ $30– available only with the 80% Benefit Percentage option. ❑ $40– available with all Benefit Percentage options	N/A	❑ N/A ❑ $30– available only with the 80% Benefit Percentage option. ❑ $40– available with all Benefit Percentage options	N/A
Benefit Percentage of the *Maximum Eligible Expense* ("*MEE*") that the *Policy* pays. It pays for covered services after the deductible. It pays the percentage selected up to the out-of-pocket maximum. Then it pays 100% of covered charges.	❑ 50/50% ❑ 70/30% ❑ 80/20% ❑ 100% (limited availability)	❑ 80/20% ❑ 100%	❑ 50/50% ❑ 70/30% ❑ 80/20% ❑ 100% (limited availability)	❑ 80/20% ❑ 100%	❑ 50/50% ❑ 70/30% ❑ 80/20% ❑ 100% (limited availability)	❑ 80/20% ❑ 100%
Supplemental Accident ($500 per accident)	❑Yes ❑ No	N/A	❑Yes ❑ No	N/A	❑Yes ❑ No	N/A
Prescription Benefit **Rx 2 -$10/$30/$150** **Rx 3 -$20 or 20% co-pay** **Rx 4- Drug Card**	❑ Rx 2 ❑ Rx 3 ❑ Rx 4	Rx 4	❑ Rx 2 ❑ Rx 3 ❑ Rx 4	Rx 4	❑ Rx 2 ❑ Rx 3 ❑ Rx 4	Rx 4
RX Deductible – per benefit period/per Insured	❑None ❑$100	N/A	❑None ❑$100	N/A	❑None ❑$100	N/A

Dental Quote	
Deductible – per person	❑$25 ❑$50 ❑$100
Preventive/ Diagnostic (A)	❑80% ❑ 90% ❑100% -deduct waived for A
Basic (B)	❑60% ❑70% ❑80%
Major (C)	❑50% ❑60%
Annual Maximum	❑$1,000 ❑$1,500 ❑$2,000
Orthodontia Benefit	❑None ❑ Policy pays 50% after deductible
Orthodontia Maximum	❑$1,000 ❑$1,500 ❑$2,000
Vision – will be provided with all quotes.	

COBRA – Is your group eligible?

Some employers may be required to provide COBRA continuation coverage for employees and their covered dependents. An Employer is exempt from federal COBRA continuation coverage requirements if the Employer employed less than 20 employees for 50% or more of its regular work days for the calendar year immediately before the current calendar year. Employees means all common law employees (full-time and part-time and leased) as defined by Section 414(n) of the Internal Revenue Code

COBRA eligible? ❑ Yes ❑ No

If yes, Allegiance Life & Health Company, Inc. will administer COBRA for your group. COBRA administration fees are included within the quoted rates.

PPO

Deductible	Medical Out Of Pocket					Rx Plans		Rx Out of Pocket	Co-insurance				Co-Pay		
200	1200					Rx2	Rx3	1600		80	70		40	30	None
500	1500	2000	2500	3500	5000	Rx2	Rx3	1600		80	70		40	30	None
750	2250	2750	3750	5000		Rx2	Rx3	1600		80	70		40	30	None
1000	2000	2500	3000	4000	5000	Rx2	Rx3	1600		80	70		40	30	None
1500	3500	5000				Rx2	Rx3	1600		80	70	50	40	30	None
2000	3500	4000	5000			Rx2	Rx3	1600		80	70	50	40	30	None
2500	3500	5000				Rx2	Rx3	1600		80	70	50	40	30	None
3000	5000					Rx2	Rx3	1600		80	70	50	40	30	None
5000	5000					Rx2	Rx3	1600	100				40	30	None

Deductible	Total Out Of Pocket				
200	2800				
500	3100	3600	4100	5100	6600
750	3850	4350	5350	6600	
1000	3600	4100	4600	5600	6600
1500	5100	6600			
2000	5100	5600	6600		
2500	5100	6600			
3000	6600				
5000	6600				

Cornerstone

Deductible	Total Out Of Pocket			Rx Plan	Co-insurance		Co-Pay
1300	1300	2600	6450	Rx4	80%		N/A
2000	2000	4000	6450	Rx4	80%	100%	N/A
2600	2600	5200	6450	Rx4	80%	100%	N/A
3000	3000	6450		Rx4	80%	100%	N/A
3500	3500	6450		Rx4	80%	100%	N/A
4000	4000	6450		Rx4	80%	100%	N/A
5000	5000	6450		Rx4	80%	100%	N/A
6450	6450			Rx4		100%	N/A