Allstate®
BENEFITS

Thank You for Choosing Allstate Benefits for Your New Group Health Insurance Policy!

Below is the submission checklist in order to install a new group:

- ☐ Preliminary Enrollment Questionnaire (Following 5 pages)
- ☐ Copy of initial binder premium check being mailed* if paying via check
- ☐ Copy of group's most recent **State Quarterly Wage and Tax Report**, including pages that list each employee by name and their earnings. Please be sure to mark the employee's status next to their name (FT Enrolling, FT Waiving, PT, Terminated)
- ☐ Employee applications if not already provided (***waiting period & Cobra employees must elect or decline***)
- ☐ Employee waivers if not already provided. (only need first page **section B** completed for a waiver)
- ☐ A copy of the most recent prior medical carrier invoice listing enrolled members (if replacing coverage)

***If paying for coverage via check please make payable to:** *Allstate Benefits*
Please mail initial payment to:
Allstate Benefits

All following payments need to be sent to:
ALLIED BENEFIT SYSTEMS INC.
PO BOX 3205
CAROL STREAM, IL 60132-3205

PLEASE TAKE NOTE OF THE FOLLOWING:

***Even if you are not waiving the waiting period we still need an enrollment or a waiver for all full time employees. If you are not waiving the waiting period and a person waives at enrollment they cannot enroll until the group's next year open enrollment**

Allstate BENEFITS

Preliminary Enrollment Questionnaire

1. Effective Date of Coverage_____
2. Agent Name_____
3. Company Name:_____
   DBA:_____
4. Employer Street Address:_____ _____
   City:_____County:_____State:_____Zip:_____
   Mailing Address (if different):_____
   City:_____County:_____State:_____Zip:_____
5. Phone Number:_____
6. Fax Number:_____ _____ ____
7. Contact Person:_____Title:_____
8. Email Address:_____ _____
9. Owner(s) Name(s):_____
10. Name of authorized signer for group:_____ _____
11. Email address of authorized signer:_____
12. Nature of Business:_____ _____
13. Type of Ownership/Filing Status:
    - ☐ Proprietorship
    - ☐ Partnership
    - ☐ C-Corp.
    - ☐ S-Corp.
    - ☐ Government
    - ☐ Other_____
14. Federal Tax Id:_____
15. How long has the company been in business? _____
16. Employer Contribution towards EE Premium:_____%
17. Check or Online Payment?_____

18. Waiting Period for employees hired after plan install:
    (The effective date will be on the first billing cycle following the date the employee satisfied their waiting period)
    - ☐ 0 days
    - ☐ 30 days
    - ☐ 60 days
    - ☐ 90 days* (coverage will begin on the 91st day of eligibility)

19. Are you waiving the waiting period for all eligible employees for the group's initial enrollment date?
(Groups with 25 or more enrolling employees cannot elect yes for this option)

☐ Yes
☐ No

20. Will this new group plan replace other group medical coverage?

☐ Yes
☐ No

If yes, is your current plan Fully Insured or Self-Funded?

☐ Fully Insured
☐ Self-Funded

Name of carrier_____

Effective Date: _____ Termination Date:_____

Group Policy Number:_____

21. Will you be offering another group medical plan in addition to this group plan?

☐ Yes
☐ No

22. Do you want your medical plan deductible to reset on January 1st or when your plan renews?

☐ January 1st (deductible usage will be credited from former group plan if applicable)
☐ Plan renewal date (the month the plan started)

23. Did you employ 20 or more full-time equivalent employees for at least 50% of the previous calendar year?

☐ Yes
☐ No

24. COBRA Enrollment:

a) Do you want to offer COBRA if your future group size does not require this?

☐ Yes
☐ No

b) Please indicate your medical Cobra Administrator:

☐ National General (free)
☐ Other:_____

25. Total number of employees Including owners, partners, etc.) working in your business_____

a) How many are Full-time employees?_____
b) How many are Part-time employees?_____

26. Are any former employees on or eligible to elect continuation (Cobra)?

☐ Yes (Names:_____)

☐ No

27. Are any employees currently absent due to illness of injury? Family Medical Leave or receiving disability benefits?

☐ Yes (Names:_____)

☐ No

28. How many hours must an employee work per week between 20-40 to be considered eligible for coverage on this insurance plan?_____

29. Do you currently or in the next 12 months want to allow 1099 paid employees to be eligible for the benefit coverage?

☐ Yes

☐ No

30. Do you currently have a Cafeteria Section 125 POP plan in place?

☐ Yes

☐ No

Affiliated Companies and Multiple Locations

31. Does your business have more than 1 physical location?

☐ Yes

☐ No

32. Does your company have other business organizations under common ownership or more than one Federal Tax ID Number?

☐ Yes

☐ No

If "Yes" to either question 31 or 32 please complete the following (including main location)

Business Name:_____

Business Address:_____

Owner(s):_____

Nature of Business:_____

Tax ID:_____

FT Employees_____PT Employees_____

For additional locations continue on next page

Business Name:_____

Business Address:_____

Owner(s):_____

Nature of Business:_____

Tax ID:_____

FT Employees_____PT Employees_____

Business Name:_____

Business Address:_____

Owner(s):_____

Nature of Business:_____

Tax ID:_____

FT Employees_____PT Employees_____

Business Name:_____

Business Address:_____

Owner(s):_____

Nature of Business:_____

Tax ID:_____

FT Employees_____PT Employees_____

Business Name:_____

Business Address:_____

Owner(s):_____

Nature of Business:_____

Tax ID:_____

FT Employees_____PT Employees_____

Business Name:_____

Business Address:_____

Owner(s):_____

Nature of Business:_____

Tax ID:_____

FT Employees_____PT Employees_____