FUNDING ADVANTAGE

An Alternative Funding Group Health Plan

Plan Brochure - Effective 7/1/2011






Administered by:
Allied National
www.alliednational.com

Stop Loss Insurance Underwritten by:
American Alternative Insurance Corporation
Rated "A+" (Superior) by A.M. Best Co.

ALLIED® NATIONAL

The RIGHT Benefits. The RIGHT Price.

Do you receive money back from your insurer for being healthy?

What is the Allied Funding Advantage Plan?

Funding Advantage is a unique answer for smaller employers trying to save money on the cost of group health insurance. An Alternative Funding Plan allows you to save money by paying for the cost of small claims while providing you absolute financial protection if those claims grow larger.

Who is the Plan For?

The Funding Advantage plan is for employers with 10 to 99 employees with good health experience who feel they are paying too much premium for too little in benefits. Do you receive money back from your insurer for being healthy? If the answer is NO, then Funding Advantage could be the right alternative for you.

How Does the Plan Work?

Funding Advantage saves you money by paying the claims of your employees with your own money instead of insurance premiums. Money left in your account is your savings and not insurance company profits. You're also protected with Stop Loss insurance that provides coverage if claims grow larger.

- Stop Loss insurance protects you when an employee has a serious claim or more employees have claims during the year than you can afford to pay.
- Each month you make a single payment that covers Stop Loss insurance, administrative and sales fees, and the contribution to your claim fund. You never have to pay more than this amount – your maximum liability is determined in advance. You pay 1/12 of your maximum annual cost each month and once those 12 months are paid, you're done, even as claims continue to be processed and paid. You are never asked to pay extra if claims go past the maximum amount.
- After all claims have been paid for the plan year (after the 9-month run-out period), any unused dollars in your claim fund are yours to use as you want – to be refunded or used to lower costs for the next year.

How is This Plan Different From My Current Plan?

If you're currently covered under a fully insured plan, your monthly premium costs are locked in. Even if you're healthy and have no claims, you don't share in the savings, which are kept by the insurance company.

With Funding Advantage, and the smart use of Stop Loss insurance, you pay a monthly cost that is your maximum cost. No matter how much your claims are in a month, you will never pay more than this monthly cost. After all of your claims are paid for the year, the unused money in your claim fund is returned to you.

What Are My Risks With This Plan?

With Funding Advantage, your only risk is that you won't receive money back at the end of the plan year. Each month, your payment helps to build up your claim fund. The unused money in your claim fund is yours after claims are paid for the plan year.

Your only risk is not receiving money back at the end of the year!

What Are the Advantages of the Funding Advantage Plan?

- You don't buy insurance for benefits that you don't use. Your unused claim fund is yours at the end of the plan year.
- Stop Loss insurance fully protects you from larger claims. You will never have to pay more than the maximum monthly cost.
- The predictability of a level monthly cost - there are no extra charges to you if you have high claims.
- Your plan is an ERISA plan that is exempt from some of the new federal Affordable Care Act regulations - particularly those parts that may cause fully insured premiums to climb substantially in 2014.

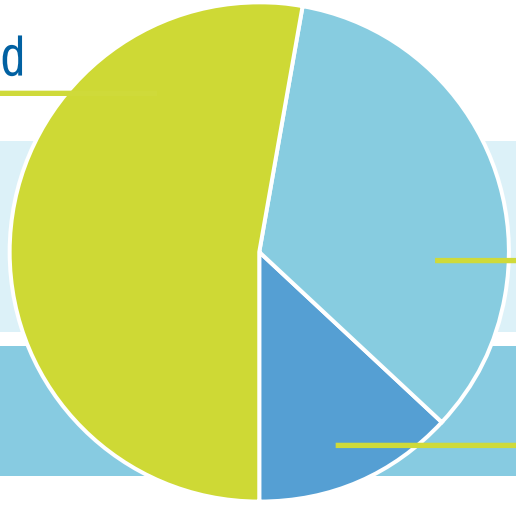
Pride in WHO We Are

The RIGHT Benefits. The RIGHT Price.
Allied National ... Today and Tomorrow.

Allied National is an administrative organization that works with major national insurance companies providing quality insurance benefit plans for employers and individuals since 1970. As a family-owned company, we take pride in our history of fast and friendly service to our customers.

How Funding Advantage Works

Your monthly costs are made up of three charges:



Your Claim Fund

Your maximum annual claims costs are predetermined and you pay 1/12 of this cost each month for the 12 months of your plan year. After you've paid this amount, there are no other charges for the claim fund. Once all claims have been paid for the plan year, any unused dollars in the claim fund are yours.

- Monthly Accommodation – If at any time the money necessary to pay smaller claims is not in your claim fund (this is common during the early months of a plan year), the insurer will advance this money to your claim fund to pay these claims. Subsequent monthly payments into the claim fund will be used to repay this advance.
- Reporting – Each month, you will receive an accounting report on all claims paid during the month and the plan year-to-date. Each quarter, you will receive a detailed report about claims paid (subject to federal and state privacy regulations). This reporting provides the information necessary to fully track your claim fund and to understand where your claim fund dollars are spent (such as doctor's office visits, prescription drugs, outpatient services and hospitalizations). With this information, you can design your plan to hold costs down at renewal.
- Plan Year & Terminal Liability – Your plan year runs for 12 months from your effective date. Claims incurred during your plan year will be paid though a 9-month run-out period after the end of the plan year. Any remaining money in the claim fund at the end of the run-out period is refunded to you. Terminal Liability coverage is built into the plan by providing the 9-month run-out period.

Stop Loss Coverage

Stop Loss coverage protects you from larger claims. The insurer pays for larger claims so the money does not come out of your claim fund.

- Specific Stop Loss Coverage – This pays when the claims for any one person (employee or dependent) exceed a set dollar limit during the plan year.
- Aggregate Stop Loss Coverage – This pays when the overall claims for your group exceed a set dollar limit during the plan year. This is the ultimate protection that allows your maximum cost to be known and locked in for the year.

Administrative & Sales Costs

These are the costs you pay for the administration of your group's health plan. This includes underwriting, claims processing and monthly claim fund reporting. Compensation is also paid to your agent from these costs for their role in helping you tailor your plan and managing your plan enrollment.

ERISA Explanation

What is ERISA?

Your Funding Advantage health plan is primarily governed by federal ERISA laws (ERISA is the Employer Retirement Income Security Act which governs employee welfare plans). ERISA establishes minimum standards for retirement, health and other welfare benefit plans. ERISA plans do not have to follow state benefit mandates resulting in lower costs and expenses.

What is an ERISA Plan?

To your employees, the ERISA plan of benefits described in the Summary Plan Description (SPD) is the standard health benefit plan description they are used to seeing with a fully insured plan. Multiple benefit options for copays, deductibles, and out-of-pocket costs are available so that you can build a plan of benefits that fits your needs. An SPD is provided to each insured employee detailing their benefits.

What Plan Options Can I Choose?

Funding Advantage has a wide array of plans and options you can choose to customize your ERISA benefit plan.

- Premium Advantage – Traditional PPO coverage plans.
- HSA Qualified – High Deductible plans that qualify for Health Savings Accounts.
- Indemnity Freedom – A new plan from Allied that provides you true choice of any provider (no PPO panels) with the savings and protections of a typical PPO plan.

As you choose benefits like higher deductibles, it has a significant impact on your monthly costs. Your claim fund and Stop Loss insurance coverage costs will vary with your choice of ERISA benefits.

Additional Plan Benefits and Savings

Funding Advantage provides you with multiple ways for your enrolled employees to save money. You're provided with access to:

- Lab Card® Benefit Program – Savings on outpatient lab testing.
- My Health Assistant – Access to Nurse and Physician hotlines, health information and patient advocacy programs.
- BridgeHealth Benefit – Access to health care Centers of Excellence around the country with expanded benefits for serious health conditions.
- Wellness Benefits – Coverage for eligible preventive care services is paid at 100% with no out-of-pocket costs.

Premium Advantage Plans

The Premium Advantage Plans feature traditional PPO health plans with a wide variety of benefit options. You can custom-build a plan to fit your needs from a wide choice of copays, deductibles, coinsurances and out-of-pocket maximums. With deductibles from $500 to $3,000, you can select the benefit and contribution that's right for your group.

If affordability is key, our higher deductible plans provide significant discounts plus comprehensive coverage that is there when needed. Combined with the optional office visit copay, prescription drug card and $500 Supplemental Accident Benefit, a high deductible plan still provides the essential benefits that you use the most and gives you great savings with a quality health care plan.

You can even design multiple benefit plans (e.g., a high and low benefit option) and allow your employees to select the one they prefer. Significant employer savings result from sponsoring (funding) a lower cost benefit option and offering employees the option of selecting a more expensive, buy-up option.

PREMIUM ADVANTAGE PLAN OPTIONS

Choose an Office Visit Copay:

• None • $30 • $35 • $40

Office visit copays do not apply to applicable deductibles or out-of-pocket maximums.

Choose a Deductible:

• $500 • $750 • $1,000 • $1,500
• $2,000 • $2,500 • $3,000

Family limit for in-network deductibles is two times the individual limit. Out-of-network deductible is two times the in-network deductible. There is NO family limit for out-of-network deductibles.

Choose a Coinsurance:

• 80% / 50% • 50% / 50%

Percentages listed as in-network/out-of-network coinsurance.

Choose an Out-of-Pocket Maximum:

• $1,500/$3,000 • $2,000/$4,000 • $2,500/$5,000
• $3,000/$6,000 • $4,000/$8,000 • $5,000/$10,000
• $7,500/$15,000 • $10,000/$20,000

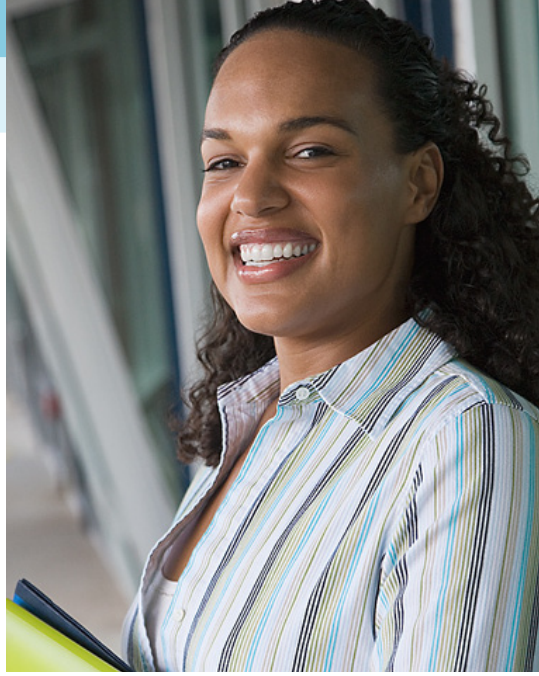
Dollar amounts listed as in-network/out-of-network maximums. Deductibles do not count toward out-of-pocket maximum. Family limit for out-of-pocket maximum for in-network and out-of-network services is two times the individual limit.

Not all benefit combinations are available. See Allied proposals for details.

Indemnity Freedom Plans

- These plans allow you the full choice of health care providers without restrictions or penalties. There are no preferred providers or networks required. See the provider YOU choose!
- You still receive the value of PPO-like discounts for all medical services. Allied arranges for these discounts directly on your behalf with the provider of your choice, to gain the highest level of discounts possible. If there is a disagreement between Allied and a provider on the fee for a service, we will negotiate directly for you to ensure there is no "balance bill" to you for discounts taken. The only out-of-pocket expenses are normal deductibles and coinsurance.

Benefit Plan Options



HSA Qualified Plans

Allied provides comprehensive solutions using the "triple tax savings" of Health Savings Accounts (HSAs) and our quality benefit plans. HSAs work with high deductible health plans (HDHPs) to provide a great alternative to traditional health plans.

HSAs make sense for a lot of people. The cash savings of an HDHP can be used to provide the funding for a tax-favored HSA. HSA contributions are tax-deductible, the earnings in the savings account are allowed to grow tax-free, and any money spent on qualified medical expenses is tax-free, providing you with powerful "triple tax savings" to help you with your medical costs.

HSA PLAN OPTIONS

Choose a Deductible:

• $1,500 • $2,000 • $2,500 • $3,000 • $3,500 • $4,000 • $5,000

Family in-network deductible is two times the individual deductible. For aggregate deductibles, entire family deductible must be met before a benefit is paid on any family member. Out-of-network deductible is two times the individual deductible. There is no family limit associated with the out-of-network deductible maximum. Choose aggregate or embedded deductible starting at $2,500.

Choose a Coinsurance and Out-of-Pocket Maximum:

Coinsurance	Out-of-Pocket Available	Coinsurance	Out-of-Pocket Available
100% / 70%	$0/$6,000	80% / 50%	$1,500/$3,000
			$2,000/$4,000
			$2,500/$5,000
			$3,000/$6,000

Family out-of-network maximum is two times the individual maximum. Due to HSA regulations, an individual's maximum out-of-pocket expense (including deductibles and copays) cannot exceed federally set maximums that can change annually. Therefore, individual in-network deductible and out-of-pocket maximum combinations chosen cannot exceed current allowable maximums.

Not all benefit combinations are available. See Allied proposals for details.

INDEMNITY FREEDOM PLAN OPTIONS

Choose an Office Visit Copay:

• None • $30 • $35 • $40

Office visit copays do not apply to applicable deductibles or out-of-pocket maximums.

Choose a Deductible:

• $500 • $750 • $1,000 • $1,500 • $2,000 • $2,500 • $3,000

Family limit for deductibles is two times the individual limit.

Choose a Coinsurance:

• 80% • 50%

Choose an Out-of-Pocket Maximum:

• $1,500 • $2,000 • $2,500 • $3,000 • $4,000 • $5,000 • $7,500 • $10,000

Family limit for out-of-pocket maximum for services is two times the individual limit.

Not all benefit combinations are available. See Allied proposals for details.

Benefit Plan Features and Options

Pregnancy Coverage: Mandatory for all groups.
Occupational Coverage: Owners, partners and corporate officers not covered by Workers' Compensation may elect to be covered on a 24-hour basis under this plan. If elected, all eligible owners, partners and corporate officers must take this coverage.
$500 Supplemental Accident Benefit: Pays 100% of charges incurred due to an accident, up to a $500 benefit. (Not currently available with HSA Qualified Plans.)

Outpatient Prescription Drug Benefit Options

The following outpatient prescription drug benefit options are available with the **Funding Advantage** plan:

- **Discount Only:**
  No outpatient prescription drug coverage.
- **Generic Only:**
  Generic: $15 copay per prescription. No limit on number of prescriptions. No Annual Maximum Benefit per calendar year. Brand name: Provided at Allied's contracted discount.
- **Deductible Integrated Benefit Options:**
  Outpatient prescription drug benefits subject to the plan's major medical deductible. After the deductible, prescription benefits are covered under the formulary plan. There are two plan options. Option one benefits subject to normal copays, option two copays are waived for tiers 0, 1 and 2.
- **Formulary Plans:**
  The base formulary plan is as shown in the chart. The formulary plan is available with a variety of deductible and maximum benefit options based on other plan benefits being selected.

Note: Total Rx benefits are subject to major medical calendar year and lifetime maximum benefit limits.

Formulary Plan Copays		
Tier	**Description**	**Patient Pays**
0	Prescribed Over the Counter	$3 Copay
1	Generic	$10 Copay
2	Brand-name Formulary	$30 Copay
3	Brand-name Non-Formulary	$50 Copay
4	Specialty Pharmacy*	50% Coinsurance

*Specialty Pharmacy includes, but is not limited to, select drugs for treating enzyme deficiency, hemophilia and multiple sclerosis, as well as select types of drugs like blood modifiers (e.g. Epogen, Procrit), growth hormones, IGIV and Interferons.

Benefit Enhancements Features

The following features, and the costs for them, are built into your Benefit Plan and included in your monthly charges.

Lab Card® Benefits: Funding Advantage extends an additional benefit with the Lab Card® Program. This program provides outpatient lab testing at no charge to your employee and at a greatly discounted charge to the plan when performed at a Quest Diagnostics facility or a doctor's office that sends the tests to a Quest Diagnostics facility. It is a voluntary program, meaning you can choose not to have your testing done using the Lab Card; however, you will be responsible for coinsurance or copay for laboratory charges. HSA High Deductible Health Plans are enrolled in the Lab Card program. You can receive and pay for **discounted** lab services that will be automatically applied to the HSA deductible. Once the deductible is satisfied, Lab Card benefits are then paid at 100%.

Wellness Benefit
Funding Advantage provides preventive benefits in accordance with the Patient Protection and Affordable Care Act of 2010. This includes all eligible preventive care services covered at 100% in-network. (100% with any provider under Indemnity Freedom Plans.)

My Health Assistant
Participants in the plan have access to the My Health Assistant program. My Health Assistant helps manage health care needs by giving you access to an array of cost-effective services. With the My Health Assistant membership, you receive:

- 24-Hour Nurse Hotline
- Online Physician Access
- 24-Hour Physician Telephone Consultation
- Patient Advocacy
- Online Health Information Library

The program is easy to use, and is provided at no additional cost.

BridgeHealth Benefit
Funding Advantage has been enhanced to offer you unprecedented access to some of the best surgeons and Centers of Excellence in the U.S. through the BridgeHealth World-Class Provider Network™. This enhancement not only gives you access to high-quality specialist care, it also allows you to view quality reports to compare hospitals and doctors in the BridgeHealth Network with your local providers. The BridgeHealth Benefit also includes a Travel Benefit, providing financial assistance to help offset your out-of-pocket costs, such as copays, deductibles and coinsurance to those who qualify. For more information, please visit *www.bridgehealthmedical.com/allied*.

Eligible Expense Summary

The following outlines the general plan of benefits designed into Funding Advantage. For more information, including limitations and exclusions, please review the Summary Plan Description (SPD). A sample is available from your agent.

Doctor's Office Visits: The Office Visit Benefit, when selected, applies to services performed in the doctor's office (office visits, urgent care and emergency room subject to deductible on HSA plans) such as exams, consultations, and most diagnostic and surgical services. After the office visit copay, these services are paid at 100% to a total benefit of $200 per office visit. Eligible expenses beyond $200 are applied to deductible and coinsurance. For PPO plans, out-of-network office visits are subject to applicable out-of-network deductible and coinsurance. For plans with two or four annual office visit limits, additional visits are subject to deductible and coinsurance.

Urgent Care Services: Are subject to the doctor's office visit copay plus $20 (urgent care copay). Benefits payable same as for doctor's office visits after the urgent care copay. (Not applicable to HSA plans.)

Emergency Room Services*: $100 copay, then subject to coinsurance. (Not applicable to HSA plans.)
** Copays do not apply to deductibles or out-of-pocket maximum.*

Out-of-Network Charges from Non-PPO Providers (not applicable to Indemnity Freedom plans): Paid at lesser of 80% or in-network coinsurance if injury or sickness occurs outside the PPO service area while traveling for 90 days or less, while permanently residing outside the service area, while attending school full-time outside the service area (dependent child only), or when receiving services at a PPO hospital from a non-PPO provider. These charges apply to out-of-network deductible and out-of-pocket maximum.

Routine Exams and Immunizations for Children: Subject to schedule of visits as established by law.

Hospital Daily Rate (Including Nursing Charges):
- Ward and semi-private: Full amount up to semi-private room.
- Observation Room: Semi-private room prorated.
- Intermediate Care Unit and Step-Down Unit: Two times semi-private room.
- Private Room: Semi-private room.
- Intensive Care Unit: Three times semi-private room.
- Skilled Nursing Unit: Full amount up to 50% semi-private room .
- Extended Care Facility: Daily rate not to exceed a daily benefit of $125 for 60 days during any calendar year.

Calendar Year Maximum Treatment Days for inpatient hospital confinement for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care): 31 days. Paid same as any other illness on groups subject to federal parity laws.

Calendar Year Maximum Aggregate Benefit (except as otherwise indicated in the Schedule of Benefits): As mandated by Federal law. Currently $1,000,000 in 2011, $1,250,000 in 2012, $1,750,000 in 2013 and unlimited in 2014.

Lifetime Maximum Benefit per Human Organ or Tissue Transplant: If insured person is not under health care coordination: 50% of charges to maximum benefit of $100,000. Human organ or tissue transplant from a donor: $10,000.

Lifetime Maximum Benefit for Allergy Testing and Allergen Immunotherapy: $500

Lifetime Maximum Benefit for Durable Mechanical Medical Equipment: $5,000

Lifetime Maximum Benefit for Orthotics and Orthopedic Devices: $5,000

Lifetime Maximum Benefit for Physical Diagnosis or Treatment of Infertility Conditions: $500

Lifetime Maximum Benefit for Hospice Care:
One benefit period not to exceed six months.

Implantable Devices: 150% of cost.

Pregnancy Care Benefit for Employee or Spouse Only: Payable same as any other sickness.

Complications of Pregnancy: Payable same as any other sickness.

Well Baby Care: Two days payable same as any other sickness.

Calendar Year Maximum Visits:
- Orthopedic Manipulation, Occupational Therapy, Massage Therapy, Physical Therapy and Acupuncture: 20 visits.
- Home health care: 40 visits.
- Outpatient care for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care): 26 visits. Paid same as any other illness for groups subject to federal parity laws.
- Speech therapy: 20 visits.

Out-of-Network Limitations (not applicable to Indemnity Freedom plans):

Office Visit and Urgent Care Copay: Subject to applicable out-of-network deductible and coinsurance.

Deductible: Additional deductible: Two times in-network deductible. No family limit for out-of-network deductibles.

Out-of-Pocket Maximum: Additional, equal to two times in-network out-of-pocket maximum. Family limit is two times individual limit.

See the Summary Plan Description for complete details.

Plan Provisions

The following information describes Funding Advantage plan benefits and requirements. Exact provisions for the plan are contained in the Summary Plan Description. Each insured employee will receive a Summary Plan Description, which contains a detailed explanation of the plan provisions.

Final rates and eligibility for all groups are determined at the time of underwriting. DO NOT cancel current coverage until your new group coverage has been approved in writing by Allied.

Please contact Allied Sales Support at 888-767-7133 for up-to-date information and to discuss special underwriting situations.

Participation, Contribution Requirements and Eligibility

A minimum of 10 covered employees is required at all times, and a minimum employee participation of 75% of the eligible employees must be enrolled. Any employee who waives coverage because they have a qualifying existing coverage is not counted in the above participation totals (unless the qualifying coverage is another plan with that same employer). However, at least 50% of the full-time employees must participate in the plan for the group to be considered eligible. The employer must contribute a minimum of 25% of each employee's contribution costs. There is no minimum participation requirement for dependents.

Eligibility: An eligible employee is a person directly employed and actively at work (including approved medical leave) on a full-time basis in the regular business of the employer, and compensated by the employer with regular periodic wages for service. Full-time is at least 30 hours per week unless otherwise specified.

Eligible dependents are an employee's legal spouse who is not legally separated or divorced from the employee and is not a member of the armed forces, and an employee's children, including stepchildren, legally adopted or foster children, under the age of 26.

Waivers

Waivers must be completed for ALL eligible employees and/or dependents not enrolling for coverage. If the waiver is because of qualifying existing coverage, the waiver will not count against the calculation of the group's participation. An employee's failure to complete a waiver could jeopardize his or her future rights to coverage.

Pre-Existing Conditions

A pre-existing condition is a bodily injury or sickness, whether a physical or mental condition, regardless of the cause for the condition, for which medical advice, diagnosis, care or treatment was recommended or received by an insured person within the six month period ending on the enrollment date. Medical advice, diagnosis, care or treatment will be taken into account only if it is recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law. A pregnancy existing on or before the enrollment date is not considered a pre-existing condition. No benefits are payable for a pre-existing condition until a continuous period of: (a) 12 months from the enrollment date, with respect to other than late applicants, and (b) 18 months with respect to late applicants, has elapsed. On major medical plans, children and employees age 18 or less are not subject to a pre-existing limitation.

A pre-existing conditions benefit allowance of $1,000 will be provided to an insured person who does not qualify for credit toward satisfying his/her pre-existing condition exclusion period as described above.

Takeover Benefits

Takeover benefits allow a group to switch coverage while maintaining valuable credit toward such things as deductibles and pre-existing condition exclusion periods.

Takeover benefits provide:

- Credit for prior "Creditable Coverage" applied toward the pre-existing condition limitation if there has not been a break in coverage exceeding 62 days. The "portability" provisions apply to all initial insured members and subsequent timely additions to a group. Creditable Coverage also applies to individual plans, so even new employees can qualify.
- Credit will be granted for deductible amounts satisfied under a prior Creditable Coverage during the 90 days prior to the effective date or current calendar year, whichever is greater.

Prescription Drug Coverage

Each employee will receive a prescription drug ID card that can be used at participating pharmacies across the nation, including most of the major national chains. Participants may also purchase maintenance drugs through the mail. For more information, please visit Allied at *www.alliednational.com*.

The following prescription drug restrictions apply:

- Copay, deductible and coinsurance amounts do not count toward satisfaction of deductible and out-of-pocket costs under the plan, except under the deductible integrated benefit option.
- Benefits are based upon the contracted price or the maximum allowable cost as determined by the prescription drug card service. The maximum allowable charge is the ceiling price set by the prescription drug card service on the generic equivalents of a brand-name drug.
- If a brand-name drug is prescribed with no substitutions allowed, the insured member pays the applicable brand-name copay and coinsurance. If a brand name drug is requested by the insured when the prescription allows generic substitutions, the insured is also responsible for the additional cost difference between the brand-name drug and the generic alternative.

Pre-Notification

The Funding Advantage plan assists the employee and his or her family with medical education, high-risk monitoring programs, and coordination of treatment plans with doctors and hospitals. These services help ease a patient through the medical process and control expenses to the benefit of all participants.

We request that participants give pre-admission notification in the following instances:

- Within 30 days from the date of diagnosis of a pregnancy.
- Outpatient services exceeding $5,000.
- Inpatient admission and treatment.
- Human organ or tissue transplants.

Group Enrollment Requirements

To submit a group for the Funding Advantage plan:

1. Submit a copy of the benefit and rate proposal used for the group.
2. Have the employer complete, sign and date the Employer Application in ink.
3. Have each employee complete, sign and date an employee enrollment form in ink. Make sure all questions on the applications are answered completely and accurately.
4. Any eligible employee or dependent not enrolling for coverage MUST complete a waiver form. An employee waiving coverage because they are covered under another employer's major medical plan will not be counted against the group's participation requirements.
5. Make certain all papers are signed in ink and dated, and received by Allied before the requested first of the month effective date.
6. Submit a check from the employer for the first month's costs (as shown on the rate proposal). It must be a preprinted company check payable to Allied National.
7. Submit a complete copy of the firm's most recent State Quarterly Unemployment Tax report, containing employee names, Social Security Numbers and earnings. This provides us with information necessary to verify employee participation and eligibility.
8. For currently insured groups - submit the group's most recent premium billing and proof of duration of prior coverage for each employee. Suitable proof is an individual or group certification of coverage, or copies of a premium or rate notice showing enrollment and coverage up to one year ago. This will allow Allied Underwriting to verify the proper pre-existing conditions credit for each employee.
9. All producers must be appointed with American Alternative Insurance Corporation. If not yet appointed, please contact Allied Sales Support for information.
10. Send all completed forms to your local Allied representative or mail to:

Allied National
Underwriting Department
P.O. Box 29187
Shawnee Mission, KS 66201-9187

For deliveries requiring a street address, mail to:

Allied National
4551 W. 107th St. #100
Overland Park, KS 66207
UAS Fax: 913-945-4397
Email: uas@alliednational.com

About Allied

Allied National is an administrative organization that works with major national insurance companies, providing quality benefit plans for employers and individuals since 1970. As a family-owned company, we take pride in our history of fast and friendly service to our customers. Our personal service is what sets us apart from the large companies in the industry.

Allied appreciates and preserves the idea of value. We believe the best way to deliver outstanding value is not to just offer great products and pricing, but to back our products with excellent service.

Allied has a tradition of trust. We build all our relationships and base all our services on this trust. Delivering high-quality, high-value employee and individual benefit plans is our purpose, and maintaining superb customer service is our goal. Factor in over 40 years of experience managing benefit plans and it's easy to see that Allied means good value.

We have committed ourselves to excellence. We fulfill this commitment in many ways, in everything we do. We genuinely respect others, and we treat our customers with the consideration inherent to a privately-owned business in the heart of America.

About AAIC

Your Stop Loss insurance is underwritten by American Alternative Insurance Corporation, rated A+ (Superior) by A.M. Best Company. AAIC is located in Princeton, NJ, and is a subsidiary of Munich Re America Corporation and an affiliate of Munich Reinsurance America, Inc.

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The RIGHT Benefits. The RIGHT Price.

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An Alternative Funding Group Health Plan
ADVANTAGE

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