Allstate BENEFITS

Preliminary Enrollment Questionnaire

1. Effective Date of Coverage 11/1/20
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. Payment method: ☐ Check ☐ Autopay*
    *If electing autopay please provide the following:
    Bank Name_____
    Routing Number☐☐☐☐☐☐☐☐☐
    Account Number_____
    Account Type: Checking ☐ Savings ☐
    Does the account have an ACH filter?
    No ☐ Yes ☐ If yes, please instruct your bank to add the following company ID: 363086057R
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_____