

# APPLICATION FOR THE ALLIANCE FOR SMALL BUSINESS



Group ID # \_\_\_\_\_ (office use only)

<b>Plan A</b> Pkg 1 HRA W/ Online Physician Pkg2 HRA W/ ASB Pkg 3 HRA W/ ASB/ LTD Pkg 4 HRA/ ASB/ Dental Pkg 5 HRA W/ ASB/ LTD/ Dental	<b>Plan ASB</b> (EAP) Employee Assistance Program \$10K AD&D/\$10K Group Life Online Physician Survivor Support, Travel Assistance, Life Balance \$10.81 per month (Optional LTD)-Long Term Disability	<b>Plan B</b> Catastrophic Loss Major Medical Hospital Income Protection <u>Includes ASB</u> \$10.81 per month(Optional LTD)-Long Term Disability	<b>Please check plan choice</b> Plan A (pkg#) _____ Plan ASB _____ Plan B _____ Optional LTD \$10.81/Per EE Per Month Do you have prior group LTD <input type="checkbox"/> YES/NO
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Company Name:	Address:	Contact Name:	
Email Address:	Phone and Fax #'s:	<b>Please include billing address if different than above.</b>	
			Effective Date:

Employees/Employer	Duplicate this page for additional members.						
Last Name	First Name	MI	Email	Date of Hire	Last 4 Digits of SS	Signature	Date

Agency:	Phone:	Fax:	Email:	Signature
Agent:	Phone:	Fax:	Email:	Signature
Employer Name:	Nature of Business	ERISA# or EIN#(Employer ID#)		Signature

Notes: Password will be last 4 digits of SS#----Group Number will be assigned by Alliance for Small Business

If Terminating existing Group Life Coverage, Please Check YES \_\_\_\_\_ NO \_\_\_\_\_ Carrier Name: \_\_\_\_\_

Major Medical Carriers Name \_\_\_\_\_