

Proposal Requested by:	Proposed Ef			Effective Date*:	
Company Name:		Phone Number:		Fax Number:	
Contact Person:		Contact E-mail Address:			
*Desired effective date subject to approval by Allegiance COBRA Services.					
Company Information					
Company Name:	Contact Person:				
Company Ivame.	Contac			E-mail	
Phone Number:	Fax Number:			Address:	
Address		State of Domicile:			
Ct.	G		7: 0	7: 0.1	
City	State		Zip Coo	de	
# Employees:	# Covered Employees:		Averag	e Turnover:	
# Current	" covered Employees.			Approximate # of Qualifying	
COBRA Participants:	# Locations:		1	Events in Past Year:	
•	<u> </u>				
Broker Information					
Broker Name:					
Contact Person:	Phone Number:		E-mail A	.ddress:	
1 1					
Health Plan Information					
	Carrier(s):		Renewa	al Date:	
# Medical Plans:	State situs:			=	
	Carrier(s):		Renewa	al Date:	
# Dental Plans:	State situs				
	Carrier(s):		Renewa	al Date:	
# Vision Plans:	State situs:				
Calf fundado D V DN	Open	040.			
Self-funded? ☐ Yes ☐ No	Enrollment D	aie:			
Services Requested					
Initial Notices for new Enrolled	es? HIPAA Certif	fications?	State Continuation Coverage Admin.		

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☐ Yes

☐ No

☐ Yes

☐ No

☐ Yes

☐ No