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| **NEW GROUP SET-UP FORM**Please complete this form & return to: newmembers@the-alliance.org |

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| **NEW GROUP INFORMATION** |
| Company Name: | Effective Date: |
| Local Address: | # Accessing Employees: |
| Federal ID#: | Plan Renewal Month:  |

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| **NEW GROUP CONTACT INFORMATION** |
| **Primary Contact:** |
| Job Title: |
| Email Address: |
| Phone #: |
| **Mailing Address** (*if different than physical*): |
| **Executive-Level Contact:** |
| Job Title: |
| Email Address: |
| **Privacy Officer:** |
| Job Title: |
| Email Address: |

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| **BROKER INFORMATION** |
| Agency Name: |
| Broker Name: |
| Account Manager Name: |

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| **THIRD PARTY ADMINISTRATOR (TPA) INFORMATION** |
| TPA Company Name: |
| Account Manager: |
| Email Address: |
| Phone #: |
| Claims Submission Address: |
| Toll-Free # for Enrollees: |
| Toll-Free # for Providers: |

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| **NETWORK OFFERING** |
| **Not including wrap networks**, does the Employer offer **additional primary network options or fully-insured products** forthe population who is offered The Alliance network? |
|  **Single** *(The Alliance)* **Dual** *(The Alliance or 1 other network choice)* **Multiple** **Options** |

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| **MONTHLY INVOICING INSTRUCTIONS-** Indicate who should be invoiced for the following: |
| 1. **Initial Membership & Equity Stock Purchase: TPA EMPLOYER**
 |
| Invoice Contact: | Email: |
| 1. **Monthly Retainage Fee: TPA EMPLOYER**
 |
| Invoice Contact: | Email: |
| 1. **Monthly Access Fee: TPA EMPLOYER**
 |
| Invoice Contact: | Email: |

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| **SUBGROUP BREAKOUT: INVOICING & REPORTING REQUESTS**Does the Employer want subgroups? **YES NO** If **YES**, list the Divisions/Locations & Group #’s below: |
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*\*If more room is needed to list subgroups, email the complete list to:* newmembers@the-alliance.org

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| **STOP-LOSS / REINSURANCE INFORMATION**- List the **($)** maximums for the Employer’s stop-loss (*if applicable*): |
| **Specific Stop-Loss** *(protects Employer from a high claim on any one individual)*: **$** |
| **Aggregate Stop-Loss** *(dollar amount cap on eligible expenses Employer could pay)*: **$** |

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| **VENDOR RELATIONSHIPS**-Write “NA” if the Employer does not utilize a vendor for the following: |
| Care Coordination:  |
| Dental: |
| On-site / Near-site Clinic: |
| Pharmacy: |
| Steerage: |
| Stop-Loss (Reinsurance): |
| Telemedicine: |
| Transparency: |
| Vision: |
| Wellness: |
| Workers’ Compensation: |
| Wrap Network(s): |

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| **Submit the Employer’s current SBC, SPD & ID Card(s) to:** **newmembers@the-alliance.org** |