

# CARA Allstate

## Employer Application

**Employer Group Information**

Effective Date :

Group Name :		
Address :		
City :	State :	Zip Code :
Contact Person:		
Phone :	Fax :	
Email :		

### Allstate Workplace Division

#### Life and Voluntary Workplace Benefit Plan

Select only ONE (1) option per Employer Group

<input type="checkbox"/>	<input type="checkbox"/>	<b>Number of Employees</b>
<b>Low Option</b>	<b>High Option</b>	

*Choose your Billing Cycle:*

ACH  
  Monthly  
  Quarterly  
  Semi-Annually  
  Annually

Subtotal \$

Administration Fee \* \$

ACH groups: Please complete the ACH form.

Grand Total \$

**Please make check payable to "CARA"**

\* Please refer to *AIS Administration Fee Schedule* for your choice of billing option.

**Broker Information**

Broker Name :		
Firm Name :		
Address :		
City :	State :	Zip Code :
Phone :	Fax :	
Email :		
Tax ID # or SSN # :		

**General Agent Information**

GA Name :
GA Firm Name :

**Please mail to: AIS \* One Kaiser Plaza, Suite 1333 \* Oakland, CA 94612 \* Attn: New Business**



# Allstate

Workplace Division

## Allstate Workplace Division Life and Voluntary Workplace Benefit Plan

*offered exclusively through CARA:  
for groups 1 - 200 employees*

Benefits	Low Option	High Option
<b><u>Employee Only</u></b>		
Term Life Insurance*	\$25,000	\$25,000
Critical Illness	\$5,000	\$10,000
Cancer Benefit	\$5,000	\$10,000
Wellness Benefit	\$100	\$100
<b>Weekly Premium</b>	<b>\$7.98</b>	<b>\$12.99</b>
<b>Monthly Premium</b>	<b>\$34.58</b>	<b>\$56.29</b>
<b><u>Add Family Coverage</u></b>		
	<b>Dependent Benefit Amounts</b>	<b>Dependent Benefit Amounts</b>
Term Life Insurance*	\$5,000 each dependent	\$5,000 each dependent
Critical Illness	\$2,500 each dependent	\$5,000 each dependent
Cancer Benefit	\$2,500	\$5,000
Wellness Benefit	\$100	\$100
<b>Total Weekly Premium</b>	<b>\$12.99</b>	<b>\$21.00</b>
<b>Total Monthly Premium</b>	<b>\$56.29</b>	<b>\$91.00</b>

\*Employees who are 70 and older are limited to Life amounts of \$5,000. Life amounts will be reduced to 65% of the original amount at attained age 70, 50% of the original amount at attained age 75 and 35% of the original amount at attained age 80.

**Note:** Monthly Administrative Fees: \$10 Groups 1-4, \$20 Groups 5+

Optional bank draft payment mode (ACH) \$3.50 monthly  
CARA Annual Association Due: \$15.00  
Please make check payable to: CARA

**FOR QUESTIONS: Call AIS (800) 788-6524 or visit our website at <http://www.ais-insurance.com>**

**CA License #0624927**

# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224



**Allstate**

Workplace Division

## ENROLLMENT FORM PACKAGES SBS-TC

This Box for AHL Home Office use only		
Group No.	Account	Location
Issue State	EFFECTIVE DATE	

### Section A

### GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER			DATE HIRED (MM/DD/YEAR)	
OCCUPATION	PLANT OR DIVISION	BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP	
EMPLOYEE'S EMAIL ADDRESS	Do you currently have comprehensive health benefits from either an insurance policy or an HMO plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "No", you may not apply for the coverage below.					

### Section B Yes...I want the coverage for myself (Select High or Low Option)

Employee	<input type="checkbox"/> High Option Employee Benefit Amount	<input type="checkbox"/> Low Option Employee Benefit Amount
Term Life Insurance*	\$25,000	\$25,000
Critical Illness	\$10,000	\$5,000
Cancer Benefit	\$10,000	\$5,000
Wellness Benefit	\$100	\$100

### Section C Yes...Add this coverage for my family too

Family	Dependent Benefit Amounts if High Option selected above	Dependent Benefit Amounts if Low Option selected above
Term Life Insurance*	\$5,000 each dependent	\$5,000 each dependent
Critical Illness	\$5,000 each dependent	\$2,500 each dependent
Cancer Benefit	\$5,000	\$2,500
Wellness Benefit	\$100	\$100

**If Family Coverage elected, please complete Dependent Coverage section on page 2.**

### Section D No...I do not want the coverage at this time.

I understand that by declining to enroll I will be required to produce evidence of insurability, at my own expense, if I choose to participate at a future date, including annual enrollment. Please sign and date waiver/declination section on page 2.

*\*Employees who are 70 and older are limited to Life amounts of \$5,000.  
Life amounts will be reduced to 65% of the original amount at attained age 70, 50% of the original amount at attained age 75 and 35% of the original amount at attained age 80.*

# ENROLLMENT FORM

## DEPENDENT COVERAGE SECTION

(Please complete if Family Coverage elected. Use additional paper if needed.)

Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)



**Stop. Think. Save.**  
Go green by receiving your Certificate Electronically.

### Section E

### ELECTRONIC ACCEPTANCE

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy, and its accompanying notices ("my Certificates"). If electronically delivered, I will be provided instructions on how to receive my Certificate via the following address: [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).

To electronically receive my Certificate, I must use a computer that meets the following minimum requirements: (1) Operating system with a minimum of: (a) Pentium or higher processor, (b) 16 MB random access memory (RAM), (c) 20 MB of free hard drive space; (2) Operating system Windows® XP or higher or Windows® 2000 or higher; (3) Microsoft® Internet Explorer 6.x or greater; (4) Adobe® Reader 6.x or greater; (5) Internet connection.

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive a paper copy of my Certificate, free of charge, by calling, toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

- YES, I agree to receive the Certificate and Notices electronically via the internet.
- NO, I prefer to receive paper copies of the Certificate and Notices.

A complete explanation of the coverage including exclusions and limitations can be found at [www.allstateatwork.com/sbstc](http://www.allstateatwork.com/sbstc). If you prefer to receive a paper copy from your agent, please check this box .

### Section F

**ACCEPTANCE:** I hereby request all coverage checked "yes" above for which I am or may become eligible under the group coverages issued by AHL. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed. · **WAIVER/DECLINATION:** I understand that if I refuse any coverage for which I am eligible (by checking "no" for coverage), satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Date \_\_\_\_\_ Employee's  
Signed \_\_\_\_\_ Signature \_\_\_\_\_

# CARA Membership Application

The undersigned, whose address and telephone number are shown below, hereby makes application for membership in CARA, an unincorporated association, upon the terms and conditions herein provided.

Upon payment of the membership application fee in the amount of \$15.00 and acceptance by CARA, the undersigned shall be entitled to all privileges and benefits as a CARA member, including participation in all CARA sponsored insurance programs for which such member shall be qualified and accepted.

In order to sustain membership in CARA, the member shall pay to CARA each year on or before the anniversary date of enrollment shown below, the annual dues established by the CARA Board of Directors. Said association dues shall be used by CARA solely for and in consideration of membership in the association.

The undersigned agrees to abide by the association's laws and such other membership rules as may be promulgated by the CARA Board of Directors from time to time.

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

For internal use:  
Accepted by CARA \_\_\_\_\_  
Signature

# AIS

(In Nevada, also known as EWC Insurance Services, Inc.)

## Administration Fee Schedule

<b>Monthly</b>	<b>ACH (Auto Bank Draft) <sup>1</sup></b>	<b>By Mail</b>
1 to 4 Employees	\$ 3.50	\$ 10.00
5 > Employees	\$ 3.50	\$ 20.00
CARA Annual Fee <sup>2</sup>	Waived	\$ 15.00

### Other Billing Options:

<b>By Mail</b>	<b>Quarterly</b>	<b>Semi-Annually <sup>3</sup></b>	<b>Annually</b>
1 to 4 Employees	\$ 20.00	\$ 25.00	\$ 25.00
5 > Employees	\$ 30.00	\$ 25.00	\$ 25.00
CARA Annual Fee <sup>2</sup>	\$ 15.00	\$ 15.00	\$ 15.00

**Please make check payable to “CARA”.**

<sup>1</sup> ACH groups will not receive any monthly statements.

<sup>2</sup> CARA Annual Fee is due on anniversary month.

<sup>3</sup> SINGLE employee groups requesting “Mail Billing” are required to pay semi-annually.

**AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)**

**E.W.C. INSURANCE SERVICES, INC. DBA AIS**

I (we) hereby authorize E.W.C. Insurance Services, Inc. DBA AIS, hereinafter called COMPANY, to initiate *debit entries* to my/our CHECKING account indicated below at the Depository Financial Institution named below, hereinafter called DEPOSITORY, and to debit the same to such account on the  5<sup>th</sup> or  20<sup>th</sup> of each month (select one). I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY NAME \_\_\_\_\_ BRANCH \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

ROUTING# \_\_\_\_\_ ACCOUNT# \_\_\_\_\_

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) \_\_\_\_\_ CLIENT # \_\_\_\_\_  
FOR INTERNAL USE ONLY

DATE \_\_\_\_\_ SIGNED X \_\_\_\_\_

*NOTE: All written debit authorization MUST provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization within 30 days. This form is to be submitted along with 1<sup>st</sup> month's premium and/or a copy of 'VOID' check.*

*sample check*

Any Name 1234 Any Street City, State Zip Code	DATE _____	2345
Pay to the order of _____	_____ Dollars	
<b>Bank Name</b> Main Branch 1234 Any Street City, State Zip Code (800) 555-1234	_____	
Ⓘ:123456789Ⓘ: 2345 @1234567890		
↑ Routing Number	↑ Account Number	

Depository Name →

Branch →