Med Plan 2000 ENROLLMENT CHECKLIST

Group Name _____

Address: _____

Fax # _____

Contact Name & Phone # _____

Agent Name & Phone # _____

Requested Effective Date _____

_____ Copy of Employee Applications _____ Copy of Employer Application

_____ Set-up Fee $500

_____ Employer Tax ID# _____ Company Type: ____ Corp____Partnership
____ Sole Prop____Other

_____ Submit Copy of Actual Purchase Plan Rates at Issue

_____ Active Sect. 125 pretax "Cafeteria Plan" (POP) (If No Please Contact ASI Immediately)

_____ Signed prescription claim form for each employee (BLUE SHIELD ONLY)

_____ Employee meeting scheduled for _____

MED PLAN 2000 BENEFIT

Employee Deductible _____
Employee % _____ Employer % _____ Subject to Deductible Yes ___ ($____) No ___

RX Co-Pay _____ Subject to Deductible Yes _____ ($____) No _____

Office Visit Co-Pay _____ Benefits different than above _____

Total Monthly Administration Fee: $25.00/per employee.

Please attach a "void" check from the account that claims are to be paid from below.

Starting claim check number _____

ATTACH VOID CHECK HERE

Missing information will delay the Med Plan 2000 enrollment.