

**EMPLOYEE CENSUS/CHANGE REQUEST FORM**

<b>EMPLOYER NAME:</b>					
<b>EMPLOYER ADDRESS:</b>					
<b>NAME:</b>					
		Last	MI	First	
<b>ADDRESS:</b>					
		Street	City	State	Zip
<b>PHONE:</b> (      )			<b>GENDER:</b> MALE _____ FEMALE _____		
<b>EMPLOYEE SOCIAL SECURITY NUMBER:</b>  -    -			<b>EMPLOYEE DATE OF BIRTH:</b>		
<b>HIRE DATE:</b>		<b>JOB TITLE:</b>			
<b>EMPLOYEE WORK STATUS:</b>		CHECK ONE	<b>EMPLOYEE MEDICAL PLAN STATUS:</b>		CHECK ONE
<b>ACTIVE</b>			<b>PENDING</b>		
<b>TERMINATED</b>			<b>PARTICIPATING</b>		
<b>COBRA</b>			<b>TERMINATED</b>		
<b>BENEFIT COVERAGE</b>		Check appropriate box(es):	Self	Spouse	Children   Family
Insurance Co. and Plan Name:		Total Premium Cost:	Employer Pays:		Employee Pays:

**Employee Elections**

<p>_____ I elect to join the Plan</p> <p>_____ I am currently a member of the Plan, and wish to continue my participation</p> <p>_____ I am currently a member of the Plan, but wish to terminate my participation</p>	<p>_____ I elect to not join the Plan</p> <p>_____ I wish to change some component of my participation</p>
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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Approval: \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**AUTHORIZATION RELEASE**

I hereby certify that I am a participant in Employer Name and Med Plan 2000 health benefits program. I understand that benefits are provided under this program by Employer Name and their primary health carrier. I understand that the portion of benefits provided by Employer Name are administered by ASI of Fresno, California.

I further understand that ASI may obtain data that could be construed as ‘Confidential’ or ‘Private’ and therefore authorize ASI to use it’s best effort to limit the disclosure of information to the ‘minimum necessary’ to accomplish the intended goal of the plan.

I authorize ASI to release to my employer the information contained in the Med Plan 2000 documents for the purpose of administering the reimbursement portion of Med Plan 2000 health benefits program which is the fiduciary obligation of Employer Name as established under the Med Plan 2000 Plan Documents.

I agree this authorization shall be valid for the duration of Employer Name and Med Plan 2000 health benefits program and, in the event of a termination of the Med Plan 2000 health benefits program, for a period of time not less than 90 days from the date of termination and not longer than the grace period of Med Plan 2000 plan as designated by Employer Name.

Please sign and date this form and return it to your Benefits Coordinator.

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Employee Name (Please Print)

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Employee Signature

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Date