

# ASI GROUP PARTIALLY SELF-FUNDED MEDICAL PLAN

## Employee Enrollment / Change Form

EMPLOYER INFORMATION				
Group Name _____				
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> COBRA Enrollment / Qualifying Date _____				
EMPLOYEE INFORMATION				
Last Name	First Name	Middle Initial		
Home Address	City/State	Zip Code		
Home Phone	Work Phone	Hire Date		
Social Security Number	Date of Birth	Sex		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated				
SPOUSE				
Last Name	First Name	Sex	Date of Birth	Social Security
CHILDREN				
Last Name	First Name	Sex	Date of Birth	Social Security
1.				
2.				
3.				
4.				
5.				
AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION				
I provide this information as part of my employer's application for coverage for myself and dependents listed above. To the extent that I am responsible for the payment of dental plan costs, I authorize appropriate deductions from my earnings. I authorize any "provider of care", insurer, third party administrator, or medical plan to release medical information regarding me, my spouse and/or my children as necessary and for the purpose of determining claims for benefits, quality assurance, and peer review. This authorization will remain in effect for the term of coverage under my employers dental plan. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to a copy of this authorization.				
Employee Signature: _____ Date: _____				