INFORMATIONAL FORM

MEMBER INFORMATION	
Benefit Plan:	**Coverage Type:**
Last Name:	**First Name:**
Member SS#:	**Date of Birth:**
Home Phone:	**Email:**
Mobile Phone:	**Effective Date:**
Gender: ◯ **Male** ◯ **Female**	**Height:** **Weight:**
Street Address:	**Apt#:**
City:	**State:**
Zip Code:	**Marital Status:** **Single** ◯ **Married** ◯ **Divorced** ◯
EMPLOYMENT INFORMATION	
Business Name:	**Business Phone:**
Occupation/Industry:	**Business Email:**
Business Address:	**Employment Start Date:** **Compensation Type:** **Hourly** ◯ **Salary** ◯
Actively Employed: **Yes** ◯ **No** ◯	**Hours Worked Per Week:**
SPOUSE INFORMATION *(If Applicable)*	
Last Name:	**First Name:**
SS# **Height:** **Weight:**	**Date of Birth**
DEPENDENT INFORMATION *(If Applicable up to age 26)*	
Last Name:	**First Name:**
SS# **Height:** **Weight:**	**Date of Birth:**
Last Name:	**First Name:**
SS# **Height:** **Weight:**	**Date of Birth:**
Last Name:	**First Name:**
SS# **Height:** **Weight:**	**Date of Birth:**
Last Name:	**First Name:**
SS# **Height:** **Weight:**	**Date of Birth:**
FULL NAME OF BENEFICIARY	
Primary:	**Relationship:**
Date of Birth:	**SSN:**

In the past 10 years has any applicant seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests, or has been advised to have treatment or surgery for anything of the following

a. *Heart attack, brain tumor, stroke, heart disease or heart problems?* ◯ YES ◯ NO	e. *Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder?* ◯ YES ◯ NO
b. *Cancer, tumor, lymphoma, or any type of transplant?* ◯ YES ◯ NO	f. *Seizures, epilepsy, hemophilia, Sleep Apnea or blood disorder?* ◯ YES ◯ NO
c. *Any surgery or hospitalization in the last 5 years, OR any currently pending, planned or recommended?* ◯ YES ◯ NO	g. *Diabetes, endocrine, Auto Immune, Chron's Disease or Arthritis or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+?* ◯ YES ◯ NO
d. *Emphysema or COPD?* ◯ YES ◯ NO	h. *Currently pregnant, premature delivery, or multiple births? Pending due date* ◯ YES ◯ NO

I. **Are you taking or have you taken any medications in the last 12 months? (If yes you must list all below.)** ◯ YES ◯ NO

If you answered YES to ANY of the above Health Questions, please provide explanations in boxes below

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? ◯ YES ◯ NO	Taking Medication? ◯ YES ◯ NO
Treatment Given or needed?		Medication names:		Surgery or Hospitalization?		

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? ◯ YES ◯ NO	Taking Medication? ◯ YES ◯ NO
Treatment Given or needed?		Medication names:		Surgery or Hospitalization?		

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? ◯ YES ◯ NO	Taking Medication? ◯ YES ◯ NO
Treatment Given or needed?		Medication names:		Surgery or Hospitalization?		

Billing Application

Requested effective date (mm/dd/year) ____/____/____

Billing Information – Invoices should be sent to:

_____

Contact Person **Title**

_____

Company Name

_____

Address

_____

City **State** **Zip Code**

_____

Telephone **Fax**

Representative: _____

Payment Options;

☐ EFT-Direct Withdrawal (No Charge, please complete authorization form below)

☐ Monthly Invoice ($20 Billing Fee)

EFT AUTHORIZATION

Please Note there is a $30 Insufficient Funds Fee

Bank Route Code#_____ **Bank Account#**_____

Please deduct payment of $_____ **between the 20th & 30th of the month Prior to the next months coverage.**