

Employee Enrollment

Employee Information (All information is required, including 'Annual Compensation')

FAX to 888-884-4085

AMERICAN MUTUAL BENEFITS

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Employer Name		Location/Company	
Employee Name (First, MI, Last)		SSN	Annual Compensation
Address		Home Phone	
City		State	Zip
Employee's email address		Marital Status (ie. married, single, divorced, separated)	

Family / Dependent Information (Note: If additional children are in family, attach a separate sheet giving required information.)

All participants MUST be covered by a major medical health insurance plan for participation.

	Sex (M/F)	Date of Birth	Relationship	Dependent for Taxes YES or NO
Employee				
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				
Child 5				

Employee Statement of Employer Sponsored Medical Health Insurance Coverage and Certification of Understanding

I hereby request benefits under the NOW Medical Expense Reimbursement Plan (hereinafter "Plan") and authorize my employer to deduct from my earnings any required contribution for the benefits to which I am or may be entitled. I understand that to be eligible I must be employed, and must continue to be employed, by the employer listed above for participation in the Plan. I agree to provide any documentation, including payroll records, copies of incurred expenses, etc., which the General Administrator deems necessary to establish that I initially met and continue to meet this or any other requirement for Plan participation. This agreement rolls over from year to year unless terminated earlier.

I certify that all persons for whom I am requesting participation are my legal dependents for tax purposes and are covered by my 'employer sponsored' medical health insurance plan. If this medical health insurance plan coverage ceases, participation ceases. To the best of my knowledge, the information which I provide on this form is true and correct as it pertains to my status with the Employer named at the top of this form. I understand that participation will not become effective unless the requirements of the Employer Service Agreement/Employee Enrollment

and Payroll Agreement are fully satisfied.

Should another company assume the providing of benefits offered under the Plan and the benefits provided are similar to the benefits hereunder presented to me and my dependents at the time this form was signed, the new company assuming the benefits may rely on this form as my authorization to the General Administrator and/or the assuming company to provide said benefits in accordance with my last directive to the General Administrator without filing another Employee Enrollment Form.

I further understand that if the benefits applied for become effective, I will be subject to all the terms of the NOW Plan.

I also understand that reimbursements will not be paid on expenses incurred before the effective date of the Plan.

Neither American Mutual Benefits, nor the General Administrator will be liable for reimbursements for any claims that are incurred, if required payments are not made when due to American Mutual Benefits, per Employer Service Agreement.

I acknowledge that I have received the guidelines. I further acknowledge that I will read and abide by the those guidelines, including the 90 Day Submission policy and base medical insurance requirement.

Initials

Employee's Signature

Date

X YES Sign Here >

I acknowledge that the available benefits have been explained to me. I have been given the opportunity to enroll in the plan and have elected not to enroll myself and/or my dependents. I understand that this election CAN NOT be changed until the next plan year anniversary.

Employee's Signature

Date

X NO Sign Here >