Employee Enrollment

American Mutual Benefits
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Employer Name	Location/Company	
Employee Name (First, MI, Last)	**Social Security no.**	**Employee no.** (if applicable)
Address	Home Phone	
City	State	Zip
Employee's email address	Date of Employment	

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
Employee				**YES or NO**
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				
Child 5				

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

I hereby request benefits under the Employer 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 a 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 staus 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 satisified.

Should another company assume the providing of benefits offered under the Plan and the benefits provided are similiar 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 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.

My Social Security benefits may be slightly reduced as a result of my election.

Initials **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.**

Employee's Signature **Date**

X YES Sign Here >