**American Health Resources**
**11 N. 2nd Avenue**
**St. Charles, IL 60174**
**1-800-570-3757**
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AMERICAN HEALTH RESOURCES

## AHR Benefit Election Form
## Section 105 Plan

| **Enrollment Information** | | | |
|---|---|---|---|
| Employer Name | Company Representative | Phone Number | |
| Participant name (last, first, MI) | Social security number | Effective Date | Date of Birth |
| Participant Address | City, State, Zip | Home phone | Work phone |
| E-Mail Address (optional-AHR will notify you the status of your claims) | Coverage: ☐ single ☐ employee + spouse ☐ employee + child ☐ family | Gender | Medicare ID # (HICN) |

**Reimbursement Method**

**Please select one:**

☐ Dollar limit method. AHR is commissioned to pay all claims up to $ _____ for this participant.

☐ Shared. Employee shall pay the first $ _____ out of pocket, and therefore the employer will pay up to a maximum of $ _____.

☐ Percentage. Employer shall pay the first $_____ at ___%, the next $_____ at ___%, and the next $_____ at ___%

| **Please complete if your spouse is covered by this health insurance plan.** | | | |
|---|---|---|---|
| Spouse name (last, first, MI) | Social security number | Date of Birth | Gender |
| Address (if different than above) | City, State, Zip code | Home phone | Medicare ID # (HICN) |

| **Please complete if your child/children are covered by the health insurance plan.** | | | |
|---|---|---|---|
| Child #1 (last, first, MI) | Social security number | Date of Birth | Gender |
| Child #2 (last, first, MI) | Social security number | Date of Birth | Gender |
| Child #3 (last, first, MI) | Social security number | Date of Birth | Gender |
| Child #4 (last, first, MI) | Social security number | Date of Birth | Gender |

**Participant Attestation**

Pursuant to the AHR Section 105 Welfare Benefit Master Plan ("Plan"), the undersigned elects to become a participant in that Plan.

1. Employer shall deposit funds into the AHR Administrative Account, and Participant directs AHR to pay claims from that account to the extent those funds exist. Participant understands and agrees that claims and costs not reimbursed by Employer are the sole responsibility of participant and successors.

2. Participant understands that under no circumstances shall AHR be responsible for claims exceeding the limits noted above.

3. Participant and successors jointly and severally indemnify and hold AHR and Employer harmless from any liability for effecting transactions specified in Plan Document and under items 1 and 2 above, if AHR and Employer act pursuant to the Plan or instructions given by Participant and successors. Participant agrees to notify AHR in writing of any event that could alter the Certifications made above. AHR and Employer may rely on the continued validity of this Certification indefinitely absent actual receipt of such notice.

| Participant Name (print) | Participant Signature | Date |
|---|---|---|
| | | |

Revised: 12/23/15.