American Health Resources
102 W. Illinois St.
St. Charles, IL 60174

AHR Benefit Election Form
Section 105 Plan

For AHR Use Only:

Date received
Group Number
Member Number
Effective Date

Enrollment Information

Employer Name		Company Representative	Phone Number
Participant name (last, first, MI)	Social security number	Effective Date	Coverage (family or single)
Participant Address	City, State, Zip	Home phone	Work phone

Reimbursement Method

(Company Rep. must initial one only)

_____On approval from Company Representative only.

_____Dollar limit Method. AHR is commissioned to pay all claims up to ___________ for this Participant.

______Unilimted. AHR is commissioned to pay all claims regardless of amount for this participant.

______ Shared. Employee shall pay the first $____________ out of pocket, and thereafter employer will pay up to a maximum of $______________

Additional Beneficiary Information

Primary beneficiary name (last, first, MI)	Social security number	Date of Birth	Relationship
Address	City, State, Zip code	Home phone	Work phone
Secondary beneficiary name (last, first, MI)	Social security number	Date of Birth	Relationship
Address	City, State, Zip code	Home phone	Work phone

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 Administrative Account, and Participant directs AHR to pay claims and administrative fees from that account. 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