Personal Benefits Plan
Application for Benefits

American Health Resources
11 N. 2nd Avenue
St. Charles, IL 60174
Phne: 800-570-3757 **Fax:** 888-815-3921

Employer Name: _____

Employee Phone Number _____

Application for health coverage, medical cost and discretionary benefits. When finished, simply click the 'Submit Form" button at the bottom and it will be encoded and submitted electronically. This application is confidential and will never be seen by your employer.

Personalized Individual Benefits Fact Sheet

Employee Name (last, first, MI)	Age	# of People in Household	Home Zip Code

County Where You Live	Current Coverage (Choose One)	Tax Filing Status	Monthly Insurance Premiums paid by **You**	Expected Household Income For This Year

Family Enrollment and Average Annual Out Of Pocket Expenses:

	Name (last, first, MI)	Age	Gender	Relationship	Is Person Covered Under this Employer's Plan?	Avg. Total Annual Out-ofPocket Medical Costs For this Person (Excluding Dental)	Is Healthcare coverage available elsewhere (Yes or No)	**IF YES**: How much would YOU have to pay for that coverage each month?
1	Employee			Self				
2								
3								
4								
5								
6								
7								
8								
9								
10								

A) Total: $0.00 **Total:** $0.00

B) Avg. Monthly Medical Costs: $0.00

C) Average Monthly Total Cost (medical + employee premiums): $0.00

Please list any doctors you want to be sure are in your Network:

Please list any prescriptions or medications that you want to be sure are covered:

I certify to the best of my knowledge, this information is true and complete. ☐