AHR Enrollment Form
Personal Benefits Plan

American Health Resources
11 N. 2nd Avenue
St. Charles, IL 60174
800-570-3757
888-815-3921 (fax)

Effective Date:

Enrollment Information

Employer Name	Company Representative		Phone Number
Participant name (last, first, MI)	Last 4 digits of Social security Number or other 4 digit security code	Effective Date	Plan Year:
Participant Address	City, State, Zip	Home phone	Work phone
E-mail Address		Date of Birth	

Election Amounts and Limitations

Benefits Savings Account _____ Per (__)month (__) Pay period

(__) Cures HRA (__) N2015 -17 Compensation

Employer Funded FSA _____ Per year ($500.00 annual maximum)

_____ FSA Limited to health insurance co-pays or co-insurance, or charges that apply to the health insurance deductible

_____ FSA open to any use allowed by law, including vision and dental

Survivor Beneficiary Information

Primary beneficiary name (last, first, MI)	Last 4 digits of Social security Number or other 4 digit security code	Date of Birth	Relationship
Address	City, State, Zip code	Home phone	Work phone
Secondary beneficiary name (last, first, MI)	Last 4 digits of Social security Number or other 4 digit security code	Date of Birth	Relationship
Address	City, State, Zip code	Home phone	Work phone

Participant Attestation

Pursuant to the AHR Cafeteria Plan ("Plan"), the undersigned elects to become a participant in that Plan.

AHR willl determine if your request is consistent with federal provisions. If you are changing from a prior election, the new amount you elect should be the total dollar amount of ALL contributions you want deducted for the entire Plan Year.

I authorize the amount(s) elected to be deducted from my salary/wages on a pre-tax basis. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Code Section 125, if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for eligible expenses are not filed with AHR by the claims filing deadline date following the 2 1/2 month grace period.

I further understand my enrollment and elections are IRREVOCABLE unless I have a Qualifying Status Change as defined by Federal Code. I understand I must request such change within thirty-one (31) calendar days of the Qualifying Status Change.

Participant Name (print)	Participant Signature	Date