AGMA HEALTH FUND PLAN B

ENROLLMENT FORM

Please complete and return this enrollment form at your earliest possible convenience. Failure to file an enrollment form may unnecessarily delay the processing of your claims.

PLEASE COMPLETE, SIGN AND RETURN TO:
AGMA HEALTH FUND PLAN B
C/O ADMINISTRATIVE SERVICES ONLY, INC
303 MERRICK ROAD, SUITE 300
LYNBROOK, NY 11563

SECTION I MEMBER INFORMATION

SOCIAL SECURITY NUMBER			DATE OF EMPLOYMENT
☐☐☐-☐☐-☐☐☐☐			☐☐/☐☐/☐☐
LAST NAME	**FIRST NAME**	**MI**	**DATE OF BIRTH**
			☐☐/☐☐/☐☐

ADDRESS	APT NO.	CITY	STATE	ZIP

TELEPHONE DAY: **EVENING:** **EMAIL:**

GENDER: ☐ **MALE** ☐ **FEMALE** **MARITAL STATUS:** ☐**SINGLE** ☐**MARRIED** ☐**DIVORCED** ☐**SEPARATED**

SECTION II

☐ **SPOUSE** ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE

☐**DOMESTIC PARTNER INFORMATION-** AN AFFIDAVIT OF DOMESTIC PARTNERSHIP AND DECLARATION OF FINANCIAL INTERDEPENCE FORM MUST BE COMPLETED, SIGNED AND ON FILE AT THE FUND OFFICE

FIRST NAME	LAST NAME	MI	DATE OF BIRTH	SOC SEC NO.

SECTION III DEPENDENT CHILD INFORMATION -

COPIES OF BIRTH CERTIFICATES, ADOPTION CERTIFICATES, OR PROOF OF LEGAL GUARDIANSHIP MUST BE ATTACHED. UNMARRIED DEPENDENT CHILDREN WILL BE COVERED UNTIL THE END OF THE CALENDAR YEAR IN WHICH THEY REACH AGE 25.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐
	☐☐/☐☐/☐☐		☐☐/☐☐/☐☐

SECTION IV MEMBER SIGNATURE

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ DATE:_____/_____/_____

FOR OFFICE USE ONLY

VERIFICATION BY:_____ DATE:____/____/____ ELIGIBILITY START DATE:____/____/____