

PO Box 4540, Iowa City, IA 52244
Phone (800) 552-1213

EXEC-U-CARE® MEDICAL REIMBURSEMENT INSURANCE EMPLOYEE ENROLLMENT FORM

Name of Employer		Employment Date (if applicable)	
Employer's Federal Tax ID Number		Effective Date	
Name of Insured		Birth Date / /	Occupation (if applicable)
Social Security Number	<input type="checkbox"/> Employee <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Male <input type="checkbox"/> Retiree <input type="checkbox"/> Board Member <input type="checkbox"/> Female	Exec-U-Care Office Use Only	
Spouse's Name		Spouse Birth Date / /	Process Date
Beneficiary for \$100,000 AD&D Benefit		Relationship	Certificate Mailed
Dependent Name	Date of Birth / /	Dependent Name	Date of Birth / /
Dependent Name	Date of Birth / /	Dependent Name	Date of Birth / /

I certify that my eligible dependents and I are covered by a Base Health Plan as defined in the Employer's Participation Agreement and I hereby request to be insured under the group policy(ies) issued.

_____ Date

_____ Signature

Please make a copy for your records before sending