

Dental & Vision Benefits Application

Last Name		First Name	Middle Initial	Effective Date of Coverage
Street Address				Date of Hire
City	State	Zip	Phone Number	
Social Security Number		Birthdate		Email Address

Coverage Options - Please check one:

- Dental & Vision Coverage
- Vision Only
- Dental Only

Benefit Level - Please check one:

- Single Coverage Only
- Single & Spouse Coverage (Fill out DEPENDENT INFORMATION)
- Family Coverage (Fill out DEPENDENT INFORMATION)

Dependent Information: If you selected Single & Spouse or Family Coverage please complete the following:

Name of Spouse/Dependent	D.O.B.	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If currently covered elsewhere, please complete the following:

Employer Company Name	Insurance Company	Policy Holder	Members
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I apply for coverage for each person listed and agree that we will abide by the Certificate of Coverage or Summary Plan Description. I authorize any person or entity having information regarding our medical/dental care to release that information to American Employers Group. Photo copies of this authorization may be used until I revoke authorization in writing. I agree that no claims will be covered until this application is approved by American Employers Group, or unless stated in my Summary Plan Description.

Signature	Date
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ACH Authorization Information

Professional Educational Services Group, LLC requires the monthly premium payment of Dental, Vision, Life, and Disability on an electronic payment basis. Be sure to allow 3-4 weeks for processing your application. Please include a blank, voided check or deposit slip from your designated account with this form.

Name of Financial Institution: _____

Please Select One:

- Checking Account
- Savings Account

ABA/Routing Number (9 Digits)

Bank Account Number (Including Zeros)

I authorize Professional Educational Services Group, LLC (PESG) to deduct my payments from the checking or savings account listed above for the purposes of paying for benefits applied for. I understand that I control my payments and if at any time I decide to discontinue the payment, I will notify PESG. I also understand that all information provided will remain confidential.

Signature	Date
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Health Information Authorization

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related (dental or vision) facility, Medical Information Bureau; Inc. or insurance companies that possess health information about me to furnish all such health information to A.E.G. hereinafter called the Company, upon presenting this Authorization or a photocopy.

Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to re-insurers or authorized business associates, who may be involved with my application for insurance or otherwise permitted or required by law, in which case it may not be protected under federal privacy rules, acknowledge that I have read this Authorization, understand, and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, A.E.G., PO Box 50 Caledonia, MI 49316. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company. Revocation of this authorization may result in the refusal of the Company to offer insurance coverage or pay benefits under a policy which has been issued.

_____ Signature of Proposed Insured or Parent if Proposed Insured is under 18	_____ Date
_____ Print Name of Proposed Insured	_____ Application Number (if Known)

NOTE TO MEDICAL PROVIDERS This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also know as HIPAA.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Patient Name: _____	ID Number: _____
Persons/organizations authorized to provide the information:	<u>Dentists, Vision Providers and A.E.G.</u>
Persons/organizations authorized to receive the information:	<u>Dentists, Vision Providers and A.E.G.</u>
Specific description of information to be used or disclosed:	<u>Benefit Insurance Only</u>
Specific purpose for the disclosure:	<u>To discuss benefits</u>
Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes

This authorization will expire when employee benefits change or expire.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I asked for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

III. Signature of Patient or Patient's Representative

_____ Signature of patient or patient's representative	_____ Date
_____ Printed name of the patient's personal representative	_____ Relationship to the patient, including authority for status as representative

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****