ACTION EXPEDITING

Group number: _____

Medical Application Form

Instructions: Please complete boxes outlined in **RED**

A: Personal Information

Last Name: Middle Initial: First Name:
Date of Birth: __/__/____ Social Security Number:
Street Address: Apt #:
City: State: Zip Code:
Home Phone Number: E-mail Address:
Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed
Gender: ◯ Male ◯ Female Tobacco Usage: ◯ Yes ◯ No
Occupation: Date of Hire: __/__/__
Hours: Salary:

B: Dependents to be Insured (Leave BLANK if coverage is NOT elected)

Dependent 1
Last Name: Middle Initial: First Name:
Date of Birth: ____/____/_____ Social Security Number:
Gender: ◯ Male ◯ Female

Dependent 2
Last Name: Middle Initial: First Name:
Date of Birth: ____/____/_____ Social Security Number:
Gender: ◯ Male ◯ Female

Dependent 3
Last Name: Middle Initial: First Name:
Date of Birth: ____/____/_____ Social Security Number:
Gender: ◯ Male ◯ Female

Dependent 4
Last Name: Middle Initial: First Name:
Date of Birth: ____/____/_____ Social Security Number:
Gender: ◯ Male ◯ Female

C: Prior Coverage

Did you have prior medical coverage? ◯ Yes ◯ No

If yes, please fill out the fields below:

Name of Previous Carrier:

Date of Termination: _____/_____/_____

Reason of Termination: _____

_____

Covered Individuals:

Last Name:	Middle Initial:	First Name:
Last Name:	Middle Initial:	First Name:
Last Name:	Middle Initial:	First Name:
Last Name:	Middle Initial:	First Name:

D. Acknowledgement of Coverage and Signature

Name Printed:

Signature: _____ Signature Date: __/__/____