

Employee Application for Benefit Program, Rider



777 Front Street • San Diego, CA 92101, Fax (619) 557-2343
Phone: (800) 848-3555 • Attention: Membership Department

REASON FOR SUBMISSION

New application Change of address/name Add/Delete dependent (list name below) Other: _____

EMPLOYEE INFORMATION

Last name	First name	MI	Home phone ()	Work phone ()	E-mail	
Address		City		State	Zip	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Employer name	Group #	Health plan/Insurance carrier		Member ID	Effective date	Social security number

ELIGIBLE DEPENDENTS TO BE ENROLLED

Spouse <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
Dependent <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail
Dependent <input type="checkbox"/> M <input type="checkbox"/> F	Last name	First name	MI	Birth date	E-mail

Do you or anyone listed have any other chiropractic or acupuncture benefits?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If yes, complete section below)
Name	Other employer name & address		Insurance ID/SSN		
Insurance company name	Policy number	Effective date	Coverage type: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture		
Name	Other employer name & address		Insurance ID/SSN		
Insurance company name	Policy number	Effective date	Coverage type: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture		
Name	Other employer name & address		Insurance ID/SSN		
Insurance company name	Policy number	Effective date	Coverage type: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture		
Name	Other employer name & address		Insurance ID/SSN		
Insurance company name	Policy number	Effective date	Coverage type: <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture		

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION AND PARENTAL CONSENT

I hereby authorize my physician, health care practitioner, hospital clinic or other medically related facility to furnish an agent, educator, designee or representative of American Specialty Health, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of coordination of care or for the purpose of review, investigation, or evaluation of an application or claim. I authorize American Specialty Health, or its agents, educators, designees or representatives to disclose to a hospital, health care service plan, or self-insurer any such medical information obtained if such disclosure is necessary to allow the proper coordination of care or processing of claims. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable American Specialty Health to render services and to process claims.

ARBITRATION

I understand that any disputes arising between me and American Specialty Health will be resolved through mandatory, binding arbitration. On behalf of myself and anyone enrolled hereunder, I understand and expressly agree that I am voluntarily giving up my constitutional right to have all such disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration for resolving disputes with American Specialty Health. Differences between myself (and anyone enrolled hereunder) and any agent of American Specialty Health, including any claims of malpractice, are not governed by the terms of my agreement with American Specialty Health.

- I have read, understand and agree to the terms and conditions on this form and have read the medical records release authorization and arbitration statements above.
- As a parent or guardian, I authorize the participation of any enrollee under the age of 18.

Signature:		Date:	
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