

DEAR EMPLOYEE: In order to comply with federal laws, we request that you print the information below only if all of the following applies:

- a) If you participate in the group health plan sponsored by your employer through Allied Benefit Systems, Inc., and
- b) If you have had dependent coverage through this plan during the last 12 months, and
- c) If you have had any additions to, or deletions from, your covered dependents under this plan during the last 12 months, and
- d) If you have **not** notified your employer or Allied Benefit Systems, Inc. of such deletions or additions, please complete the following, sign, stamp and return this card. Thank you.

1) EMPLOYER NAME _____

2) EMPLOYEE NAME _____

3) EMPLOYEE ADDRESS _____

4) EMPLOYEE PHONE # _____

5) Dependent Name	Birthdate	Date of Addition	OR	Date of Deletion
_____	_____	_____		_____
_____	_____	_____		_____

6) EMPLOYEE SIGNATURE _____

7) DATE: _____

PLACE
STAMP
HERE

ALLIED BENEFIT SYSTEMS, INC.

Attn: Eligibility Department

P.O. Box 909786-60690

Chicago, IL 60690