Prodegi
Corporate Benefit Services

APPLICATION FOR MEDICAL REIMBURSEMENT PLAN (MRP)

EMPLOYER'S NAME	GROUP NUMBER	LOCATION

EMPLOYEE LAST NAME FIRST MIDDLE	SEX	BIRTHDATE	SOCIAL SECURITY NUMBER

EMPLOYEE MAILING ADDRESS CITY STATE ZIP	TELEPHONE

HIRE DATE	MARITAL STATUS SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED BY ANOTHER MEDICAL INSURANCE PLAN NO ☐ YES ☐
IF YES, OTHER INSURANCE COMPANY NAME AND ADDRESS:

DEPENDENT INFORMATION

FOR DEPENDENT COVERAGE please list spouse/children below. If dependent benefits are declined, please complete WAIVER below.

ADD	DROP	LAST NAME	FIRST	BIRTHDATE	SEX	SOCIAL SECURITY #	RELATIONSHIP
		SPOUSE					
		CHILD					
		CHILD					
		CHILD					
		CHILD					
		CHILD					
		CHILD					
		CHILD					

BENEFITS APPLIED FOR

☐ New ☐ Change

Coverage For
☐ Employee Only
☐ Employee & Spouse
☐ Employee & Children

Decline For
☐ Self
☐ Spouse
☐ Children

I authorize the release of any medical or other records or information necessary to process the application, or to consider claims under this arrangement. I understand I have a right to inspect and receive a copy of my own Protected Health Information. I also understand that failure to sign this Authorization will result in my application not being considered.

X _____
Signature Date

ADMINISTRATIVE USE ONLY

EFFECTIVE DATE	TERMINATION DATE

Prodegi
PO Box 98
Worland, Wyoming 82401
Phone: 307-426-5500/800-246-4622
Fax: 307-347-6227