AMERICAN BENEFITS GROUP

DEPENDENT INFORMATION & BENEFITS CARD APPLICATION FORM

You must complete and return this form to our office - Please Print

Name: ____________________ Last Four Digits of SS#: ____________

Employer: ____________________ Email: ____________________

Please complete the following dependent information and indicate card request.

Last Name ____________ First Name ____________ Date of Birth ____________

Dependent SS#: ____________ Relationship: ☐ Spouse ☐ Dependent Card: ☐ Yes ☐ No

Last Name ____________ First Name ____________ Date of Birth ____________

Dependent SS#: ____________ Relationship: ☐ Dependent Card: ☐ Yes ☐ No

Last Name ____________ First Name ____________ Date of Birth ____________

Dependent SS#: ____________ Relationship: ☐ Dependent Card: ☐ Yes ☐ No

Please note cards are valid for three years. If you have new plan year elections, your election will be loaded onto your card on the first day of the new plan year.

____________________ ____________________

Employee Signature Date

Fax Toll Free: 877-723-0147
or email to processing@amben.com

No Fax Machine?

Mail to: American Benefits Group • PO Box 1209 • Northampton, MA 01061-1209 • 800-499-3539