



PLEASE SEND COMPLETED FORM TO: THE KEMPTON COMPANY PO BOX 54889 OKLAHOMA CITY, OK 73154-1889

ANNUAL PARTICIPANT INFORMATION FORM

TO BE COMPLETED BY EMPLOYEE: SS# _____ Name _____

1. Employer _____ Marital Status: [] Single [] Married [] Divorced

2. Name and date of birth of Spouse (if applicable) and / or other dependents.

Spouse -> _____ Dependent -> 3 _____
Dependent -> 1 _____ -> 4 _____
-> 2 _____

3. Home Address _____ Phone # (____) _____

4. Is your spouse employed? [] Yes [] No
Name of spouse's employer (if self employed, explain) _____ Phone # (____) _____
Address _____

If you do not carry medical (health) benefits through Advantage Health then you may skip to # 6.

5. Are you or any family member (regardless of age) covered for benefits by any other:

- A. Group Health Benefits of any kind through an Employer, Union, Welfare Plan, or a School?
B. Group prepayment arrangement providing for medical care and treatment?
C. Coverage of medical care expenses provided through any Federal, State, Provincial or other Governmental Agency
D. Covered under MEDICARE Hospital Insurance (Part A)
E. Covered under MEDICARE Hospital Insurance (Part B)
If you answered yes to "D" or "E" then is the person? [] Over 65 years of age? and/or [] Totally disabled?

F. If you answered "yes" to any of the above. What is the type of coverage and which family members have this coverage?

Medical [] Single coverage []
Dental [] Family coverage []
Vision [] Group policy []
Prescription card [] Individual policy []

If any of the above are answered yes, (excluding "D." & "E.") please complete the following:

Other Employer _____ Other insurance Co. or Benefits Plan _____
Address _____ Address _____
Telephone No. (____) _____ Telephone No. (____) _____ Policy No. _____

Who is the covered party? _____ Name _____ Relation _____

If Blue Cross, list group and certificate #. from Blue Cross ID card. _____ Group No. _____ Certificate No. _____

6. If you declined medical benefits for yourself and/or your dependents through Advantage Health, please complete this section.

A. Are you or your dependents covered under another plan? [] Yes [] No If yes, state the name of the coverage.

Employee -> _____
Spouse -> _____
Dependents -> _____

B. Are you or any of your dependents covered under the Continuation of Coverage provisions (COBRA)? [] Yes [] No
If yes, when does that coverage terminate? Mo. ____/Day ____ /Yr. ____

7. I certify that the information furnished by me is true and correct.

Date _____ 19 ____ Signature of Employee _____