Print Form

ATLANTIS REWARDS ENROLLMENT FORM

SUBSCRIBER INFORMATION

Last Name	First Name	MI	DOB	Sex ○ M ○ F

Social Security Number	Email Address

Home Address	Apt. No.	City	State	Zip Code

Home Phone Number	Alternate Phone	

GROUP INFORMATION

Name of Group	Group Number	Group Representative Signature

Requested Effective Date: _____

By signing below, I acknowledge that these benefits are provided by a vendor other than Atlantis Health Plan. I also acknowledge that upon termination of my medical coverage with Atlantis Health Plan, I am subject to cessation of benefits with the Rewards Program as well.

Please check the box below to select addition of the Rewards Program to your monthly premium.

☐ **Atlantis Rewards Program Rider $29.95/month.**

EMPLOYEE/APPLICANT SIGNATURE: X _____ DATE: _____

This enrollment form is for participation in the Atlantis Rewards Program. This program is not part of your health insurance benefits. The Atlantis Rewards Program provides a comprehensive discount benefits package. For a full benefit description, please refer to your Atlantis Rewards Welcome Package that will be sent to your home upon enrollment. This is not Insurance.