



GROUP EMPLOYER MEMBERSHIP APPLICATION
American Alternative Insurance Corp., Princeton, NJ
Please complete in ink and initial any alterations.

OPTIONAL BENEFIT SELECTION FORM

THIS FULLY COMPLETED FORM MUST BE ATTACHED TO THE GROUP EMPLOYER MEMBERSHIP APPLICATION

OPTIONAL BENEFIT

Serious Mental Illness Benefit (refer to attached rider for specific benefits)
for Additional Monthly Premium of: \$_____.

Yes **No**

Employer:	
Owner/Officer/Partner Name:	
Title:	
Signature:	
Date:	
<i>Administrative Use Only:</i>	Effective Date: _____ Group Number: _____