



Allied National Enrollment Recertification

I, _____, hereby certify that I have reviewed my original enrollment information on the attached enrollment form, including the medical information, and hereby certify that nothing has changed except for any information listed below:

1. Have you received any medical care since the original date of this application?
 Yes (If Yes, please provide details below.)
 No

2. Have you been advised to seek medical care or recommended to have any service or procedure since the original date of this application?
 Yes (If Yes, please provide details below.)
 No

3. Have you received a prescription for any drug not shown on the original application?
 Yes (If Yes, please provide details below.)
 No

4. Is there any other information, including, but not limited to occupation, dependent information, prior coverage information or any other information that has changed since the date of the original application?
 Yes (If Yes, please provide details below.)
 No

Please provide details to any yes answer above:

Question #	Person	Details

Attested to this day by:

Signature: _____

Date: _____

Print Signature: _____

Name of Employer: _____

File #: _____

RETURN APPLICATION TO ALLIED NATIONAL • UNDERWRITING • P.O. BOX 29187 • SHAWNEE MISSION, KS 66201-9187

Electronic copies of this application submitted via facsimile, email, or other electronic means shall be deemed an original.

Fax: 913-945-4397 • Email: uas@alliednational.com