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 #: ____