q3 *business technology corp.* ***www.selffunding.com***
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New Participant Information Form

As shown on ID card, Plan Name: _____ ID #: _____
As shown on ID card, Enrollee Name: _____ ID #: _____
Participant Name: _____ Soc Sec #: _____ Date of Birth: _____
Participant Relationship to Enrollee: ❍ *Self* ❍ *Spouse* ❍ *Child*
Is the Participant employed? ❍ *Yes* ❍ *No* If an adult child, a full-time student? ❍ *Yes* ❍ *No* ❍ *N/A*
Name of school or employer: _____ Address: _____
City, State, Zip Code: _____ Telephone #: _____
Enrolled through: _____(date) Currently carrying: _____ ❍ *Quarter hours* ❍ *Semester hours*
Please attach documentation from the school showing proof of enrollment
Does the Participant have coverage under any other Group or Insurance Plan (including employer provided coverage, private insurance, student insurance, COBRA, Medicare and Medicaid)?
❍ *Yes* (complete Other Coverage information below) ❍ *No*

Other Coverage (if applicable)

Plan Name: _____ Plan #: _____
Plan Address: _____
Plan City, State, Zip Code: _____
Policy # or Enrollee ID #: _____ Plan Telephone #: _____
If there is more than one plan providing other coverage, attach an additional sheet of paper.

Prior Coverage

Did the Participant have coverage prior to coverage under this Plan? ❍ *Yes* ❍ *No*
If yes, attach a certificate of prior coverage. If you need assistance obtaining a certificate of prior coverage, enter your daytime phone # here: _____

Prior Treatment

Your Enrollment Date is the effective date of your coverage under this Plan (or the beginning of the waiting period, if a waiting period applied to you). Enter the Participant's Enrollment Date here: _____. List any medical providers the Participant saw in the 6 months prior to the Enrollment Date, their phone numbers, and the condition(s) being treated here:

Provider Name(s)	Phone Number	Condition(s) Being Treated

List any prescription medications the Participant took during the 6 months prior to the Enrollment Date and the condition(s) being treated here:

Prescription Drug	Condition(s) Being Treated

I declare that the above information is correct and true and is the basis under which benefits are provided under this Plan. I authorize the release of any information which may be necessary in determining benefits payable under this Plan.

_____ _____ _____ _____
Signature of Participant (if an adult) Date Signature of Enrollee Date