AMI Benefit Plan Administrators, Inc.

More than just administration . . .

REQUEST FOR ELIGIBILITY DETERMINATION

COMPANY NAME _____

EMPLOYEE NAME _____

EMPLOYEE SSN _____

FIRST DATE OF HIRE ___/___/___ DATE OF TERMINATION ___/___/____

SECOND DATE OF HIRE __/___/___ DATE OF TERMINATION ___/___/____

THIRD DATE OF HIRE ___/____/___ DATE OF TERMINATION ___/___/____

FOURTH DATE OF HIRE ___/___ /___ DATE OF TERMINATION ___/___/____

FIFTH DATE OF HIRE ___/____/___ DATE OF TERMINATION ___/___/____

FOR AMI USE ONLY

☐ ENTER THE PLAN IMMEDIATELY

☐ ENTER THE PLAN ON DATE _____/_____/_____

☐ HAS NEVER MET ELIGIBILITY

CONFIRMED BY _____

DATE ____/___/____

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