

# MEMPHIS Plan Enrollment Application

## EMPLOYEE Information ONLY

\*\*\* SEE REVERSE SIDE TO ENROLL ANY DEPENDENTS \*\*\*

Name of your Employer: \_\_\_\_\_

Your Name: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
First M.I. Last

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
street

\_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
city state zip month day year

Hire Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
month day year Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Do you have third party health insurance?

Yes \_\_\_ No \_\_\_ Have you been diagnosed with any of the following conditions (check all that apply):  
 multiple sclerosis  systemic lupus  HIV/AIDS  
 hepatitis C  ALS (Lou Gehrig's Disease)  cancer  other: \_\_\_\_\_

Comments: \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Have you been hospitalized for heart disease, lung disease, or kidney disease within the last year?  
If Yes, please explain \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Are you currently in treatment by a doctor or dentist (or has treatment been recommended) for  
any illness or dental condition? If Yes, please explain. \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Have you been hospitalized or had surgery in the past two years? If Yes, please explain.  
\_\_\_\_\_

### Employee Enrollment Agreement

I (Enrolling Employee) agree that:

1. all the information on this application is true to the best of my knowledge,
2. I am currently uninsured and do not have access to affordable health care coverage,
3. I have received a copy of the MEMPHIS Plan's Enrollment Information, and I understand the covered and non-covered services, and
4. I will abide by the plan's guidelines as outlined in the Enrollment Information brochure.

*I understand that participants who are disruptive to a MEMPHIS Plan physician's office will be subject to action, up to and including termination from the plan.*

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Employer Eligibility Verification

I (Employer/Contact) certify that this employee is eligible for the MEMPHIS Plan, has had the benefits explained to him/her, and has been provided with a copy of the MEMPHIS Plan's Enrollment Information brochure.

*I pay this employee less than \$22,360 gross per year. \_\_\_\_\_ YES \_\_\_\_\_ NO  
(If the employee makes more than \$22,360, a tax return must be submitted with the application to determine eligibility.)*

Employer/Contact Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only:

Accepted by: \_\_\_\_\_ Date: \_\_\_\_\_ Location \_\_\_\_\_  
Effective Date of Coverage: \_\_\_\_\_ BCC \_\_\_\_\_ PCP \_\_\_\_\_ Hosp \_\_\_\_\_