ChurchHealth

MEMPHIS Plan Enrollment Application

PARTICIPANT Information ONLY

Employer/Self Employed/MP Direct: _____
(circle one)
Your Name: _____ Sex: Male _____ Female _____
First M.I. Last

Home Address: _____ SSN: _____
street

_____ Birthdate: _____/_____/_____
city state zip month day year

Home Phone: (_____)_____
Cell Phone: (_____)_____

Yes ___ No ___ **Do you have third party health insurance?**

Yes ___ No ___ **In treatment or treatment recommended by a doctor or dentist for any illness or dental condition?**

If Yes, please explain _____

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 (please explain)_____
_____

What is your household annual income? _____

What is your household family size that is included on your tax return? _____

Participant Enrollment Agreement

I (Enrolling Participant) 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.

Participant Signature: _____ **Date:** _____

Employer/Self Employed/MP Direct Eligibility Verification

I certify that this participant is eligible for the MEMPHIS Plan, has had the benefits explained to him/her.

This participant makes less than $24,980 gross per year. _____ *YES* _____ *NO*
(If the participant makes more than $24,980, 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_____

ChurchHealth

MEMPHIS Plan DEPENDENT Information

Employer/Self Employed/MP Direct:_____ **Participant**_____

DEPENDENT Information ONLY

Name:_____ Gender: Male_____ Female_____
First M.I. Last

Relation: spouse/daughter/son/other _____ SSN:_____ Birthdate:_____/_____/_____
(circle one) month day year

Yes ___ No ___ **Do you have third party health insurance?**

Yes ___ No ___ **In treatment or treatment recommended by a doctor or dentist for any illness or dental condition?**

If Yes, please explain _____

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 (please explain)_____

Name:_____ Gender: Male_____ Female_____
First M.I. Last

Relation: spouse/daughter/son/other _____ SSN:_____ Birthdate:_____/_____/_____
(circle one) month day year

Yes ___ No ___ **Do you have third party health insurance?**

Yes ___ No ___ **In treatment or treatment recommended by a doctor or dentist for any illness or dental condition?**

If Yes, please explain _____

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 (please explain)_____

Participant Signature _____ Date_____

Employer Signature _____ Phone:_____ Date _____