ChurchHealth

MEMPHIS Plan Enrollment Application

PARTICIPANT Information ONLY

Employer/Self Employed/MP Direct: _____
(circle one)

Your Name: _____ Sex: Male _____ Female _____
First M.I. Last

SSN: _____ Birthdate: _____/_____/_____
Month Day Year

Home Address: _____ _____
Number, Street City

_____ Home Phone: (_____)_____
State, Zip

Cell Phone: (_____)_____ Email Address: _____

Do you have third party health insurance? Yes ____ No ____
Are you in treatment or have had treatment recommended by a doctor or dentist for any illness or dental condition? Yes _____ No _____
If yes, please explain _____
_____

Have you been diagnosed with any of the following conditions? Yes____ No _____
(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 Signature: _____ **Date:** _____

Please verify that the applicant meets the qualifications. Eligible applicants must:

- Work at least 20 hours per week
- Have income at or below 200% of the federal poverty level, based on income and family size (see chart below)

2026 Federal Poverty Level – Annual Income 200%	Household/Family Size
$31,920*	1
$43,280*	2
$54,640*	3
$66,000*	4

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.

Employer/Contact Signature: _____ **Phone:** (_____)_____
Date: _____

Office Use Only:
Accepted by: _____ Date: _____
Location:_____ Effective Date of Coverage: _____