DIRECT PRIMARY CARE ENROLLMENT

PRIMARY

YOUR NAME FIRST, MI, LAST

MAILING ADDRESS | CITY, STATE, ZIP

DATE OF BIRTH | GENDER

PHONE | EMAIL

EMPLOYER NAME

DEPENDENTS

YOUR NAME FIRST, MI, LAST

MAILING ADDRESS | CITY, STATE, ZIP

DATE OF BIRTH | GENDER

PHONE | EMAIL

EMPLOYER NAME

CHILDERN

NAME FIRST, MI, LAST | DATE OF BIRTH

NAME FIRST, MI, LAST | DATE OF BIRTH

NAME FIRST, MI, LAST | DATE OF BIRTH

Please enroll me for Direct Primary Care through my employer. I authorize my company to deduct from my wages the portion of the premium that is the responsibility of the employee.

Authorized Signature:_____ Date::_____

FOR EMPLOYER ○ NEW ◉ CHANGE

Enrollment, changes and terminations need to be submitted no later than the 25th of each month. DPC Services begin on the 1st of the following month.