

Employer Community Care Member Application

Michael Martinez (MAR102)
 Business Store of Insurance



LIST BILL APPLICATION: TO BE COMPLETED BY EMPLOYER

Name of Business			Requested Effective Date		
Address			Contact Person		
City	State	Zip Code	Tax I.D. Number		
Type of business	Phone	Fax	Notes		
Email Address					

Banking Information – There is a \$25 monthly billing fee for all groups not using automatic draft. ***** If EFT, Attach Void Check *****

Bank name	Account #	Routing #	
Drivers License #	State	Expiration Date	Submit: 1. Master Application 2. Employee Applications 3. First Months Premium Mail to: My Community Care Healthcare Centers 13 E. First St. London, OH 43140
Credit Card Number	Security Code	Expiration Date	
Signature of Cardholder	Date	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Checking	

Employer Signature _____ Date ____/____/____
 X _____ / /

Completed by Agent:

Agent Name	Agent Number
Tax I.D. Number	Agent Address