My Community Care Member Services
13 E. First St.
London, OH 43140
888-884-2582

EMPLOYEE ACKNOWLEDGEMENT
ENROLLMENT FORM

First Name	**Last**	**Employer**

Your Street Address	**City**	**State**	**Zip**

By my signature below, I acknowledge and understand that the following applies to the Community Care Membership plan:

1. This is not insurance, it is a membership plan. The program is a limited Primary Care, accident and sickness plan that provides a package of limited benefits and services designed to meet the basic needs in a cost effective manner.
2. This plan is NOT major medical or comprehensive insurance and is not intended to replace, provide or modify any type of medical insurance.
3. No health questions are asked and no underwriting is involved. I cannot be turned down for membership and pre-existing conditions may be treated at any participating clinic.
4. I may use any participating clinic. I have been provided with a list of clinics. Additional clinics may be located at www.mycommunitycare.com/demo under the locations tab or I may call 888-884-2582 for any of the other participating clinics.
5. I understand there are no co-pays or deductibles required at the time of service at the participating clinics. I must provide Identification along with my membership card at time of service.
6. If I have a life threatening emergency I should go directly to an emergency room or hospital. Participating clinics are set up for urgent and primary care only.
7. If I am filling a prescription I should show my, My Community Care, card to receive the proper discount at any participating pharmacy.
8. I understand that there aren't any specialist physicians covered as part of the Community Care Plan. Prenatal and care for children under 6 months of age are not covered as well.
9. I may apply to have my membership transferred to my credit card in the event my employment is terminated. This may be done by calling 888-884-2582.
10. I am enrolling during the open enrollment period or as a result of a qualifying event.

I herby accept the membership plan as elected on my application. The plan I have elected is a Limited Primary Care plan, Accident and Sickness Coverage plan. I understand that I am NOT electing a major medical or comprehensive medical coverage. If at a later date I wish to participate in coverage's I haven't elected, I understand that my coverage is subject to the terms and conditions of the Membership plan. I understand that the coverage selected will begin on the effective date as described in the brochure. I understand my family members' coverage will not be in effect prior to my coverage.

Applicants Signature	Date