



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

**EMPLOYER ACKNOWLEDGEMENT  
ENROLLMENT FORM**

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**Employer**

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**Contact**

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**Phone**

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**Street Address**

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**City**

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**State**

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**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 to my employees a package of limited benefits and services designed to meet basic medical 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 currently in place with my employees.
3. No health questions are asked and no underwriting is involved. My employees cannot be turned down for membership and pre-existing conditions of my employees may be treated at any participating clinic.
4. My employees may use any participating clinic. I have been provided with a list of clinics. Additional clinics may be located at [www.mycommunitycare.com/demo](http://www.mycommunitycare.com/demo) under the locations tab or I may call for any of the other participating clinics.
5. If employees have a threatening emergency they should go directly to an emergency room or hospital. Participating clinics are set up for urgent and primary care only. Furthermore, 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.
6. I understand that I must pay on time, as billed or coverage will not be in effect for the month for all my employees. There will be a \$100 reinstatement fee.
7. All employees must accept or decline the plan at open enrollment or as a result of a qualifying event.
8. I have been provided with adequate information and brochures to explain the plan to employees I may contact my Community Care representative if additional supplies are needed or if I have questions.

I hereby accept the membership plan for my employees. The plan I have selected 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. I understand that the coverage selected will begin on the effective date as described in the brochure.

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Employer's Signature

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Date