

GROUP / COMPANY NAME		DIVISION		EFFECTIVE DATE			CONTRACT / ID NUMBER (official use)					
EMPLOYEE/PRINCIPAL NAME				MARITAL STATUS								
FIRST		MIDDLE		LAST		<input type="checkbox"/> MARRIED		<input type="checkbox"/> SINGLE		<input type="checkbox"/> DIVORCED		
ADDRESS				TYPE OF COVERAGE								
STREET												
CITY			STATE		LOCATION		<input type="checkbox"/> INDIVIDUAL		<input type="checkbox"/> INDIVIDUAL & SPOUSE		<input type="checkbox"/> FAMILY	
TELEPHONE (GSM)			TELEPHONE (WORK)			IT IS VERY IMPORTANT THAT EACH MEMBER SELECTS A PRIMARY CARE PHYSICIAN. ALL MEDICAL AND HEALTH CARE NEEDS MUST BE PROVIDED OR ARRANGED BY THE PRIMARY CARE PHYSICIAN. SELECT A PRIMARY CARE PHYSICIAN FOR EACH MEMBER						
( )			( )									
FIRST MI LAST (IF NOT SAME AS EMPLOYEE)			DATE OF BIRTH		SEX	GSM NUMBER		EMAIL ADDRESS				
EMPLOYEE/PRINCIPAL			DAY	MO	YR	(M/F)						
FIRST	MI	LAST	-	-								
SPOUSE			-	-								
FIRST	MI	LAST	-	-								
DEPENDENT			-	-								
FIRST	MI	LAST	-	-								
DEPENDENT			-	-								
FIRST	MI	LAST	-	-								
DEPENDENT			-	-								
FIRST	MI	LAST	-	-								

To produce the Health Insurance ID card, please capture the finger print of the right thumb of each person to be covered in the boxes below and staple the passport picture on top of the box. The thumb should be covered with blue or black ink to ensure that a clear finger print is obtained for each individual.

I have read through the registration handbook and understand the benefit plan. I also acknowledge that by completing and signing my registration form for the metro health plan, I have given consent for Metro Health HMO to request or inspect medical and other records maintained by my selected hospital for case management and complaint resolution purposes and no further written request will be necessary for the release of medical information to Metro Health HMO.

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**ENROLLEE SIGNATURE & DATE** **METRO HEALTH HMO AUTHORISED SIGNATURE & DATE**