



Cancer Care Plus

ENROLLMENT FORM

PLEASE WRITE CLEARLY: Indicate the complete name, date of birth, age and the relationship of all **Individuals enrolling in the Plan, including you.**

MEMBER DATA – Member Acc. #:

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH			AGE	SEX	EMPLOYER/BRANCH
			DAY	MTH	YR			

COVERED DEPENDENTS

LIST BELOW: *The names of your spouse and unmarried children under 19 years who are to be covered. Children up to age 23 may be covered provided they are attending full-time college or university*

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH			AGE	SEX	RELATIONSHIP TO MEMBER
			DAY	MTH	YR			
1.								
2.								
3.								
4.								

PLEASE SELECT YOUR COVERAGE: Tick ONE of the Categories below to indicate which coverage option you have selected

CATEGORY	YOUR MONTHLY CONTRIBUTIONS			
	<input type="checkbox"/>	Without Term Ins	<input type="checkbox"/>	With Term Ins
I. Member Only	<input type="checkbox"/>	\$25.37	<input type="checkbox"/>	\$40.07
II. Member and Spouse	<input type="checkbox"/>	\$48.20	<input type="checkbox"/>	\$76.13
III. Member and up to 2 dependents	<input type="checkbox"/>	\$37.54	<input type="checkbox"/>	\$59.30
IV. Member and Full Family	<input type="checkbox"/>	\$62.91	<input type="checkbox"/>	\$99.37

Signature: _____

Date: _____
Day Month Year

FOR OFFICIAL USE ONLY
Amt. Paid: \$ _____
Rec.#: _____
Date Paid: _____

SPECIAL REQUESTS:
