Membership Enrollment Form

To ensure that you are correctly enrolled, make sure to fill the form out completely. We cannot guarantee access to care if information is missing.

Benefits Coordinator Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire

Subscriber's Information

Last Name	First Name	MI	Subscriber SS#

Home Address	Apt. #

City	State	Zip Code

Male/Female	Date of Birth	Home Telephone	Work Telephone	Ext.
		( )	( )	

List below all of your dependents that are eligible for coverage.

	Name – Last First MI	Sex	Social Security Number	Birth date
Self				
Spouse				
Child #1				
Child #2				
Child #3				
Child #4				

Primary Language ______________________________ Please note any communication impairment ________________________

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining Health Insurance coverage.

Agreement – I understand that any dispute or controversy which may arise between Meridian Health Systems, Superior Administrators, Inc. or CCN and my Organization or between myself and Meridian Health Systems, Superior Administrators, Inc. or CCN, may be submitted to binding arbitration in lieu of a jury or court trial. This may not apply in all states.

Authorization to release medical records – I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all medical records which pertain to me or any member of my family, maintained by my chosen selected provider and/or specialist to Meridian Health Systems, Superior Administrators, CCN and/or any designed agent or representative for the purposes of medical treatment, care and for Meridian Health Systems, Superior Administrators and CCN's quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Subscriber's name	Subscriber's Signature	Date

Please complete and fax this form over to 866-467-1718 thanks