MEMBER ELIGIBILITY WAIVER

(Current Eligibility with Insurance and HMO Group)

I____understand I am eligible for

Member Name

____as of________________

Health Plan *Effective date*

through my____employment at

Own/Spouse/Parent

____

Name of Employer

I understand that____is my medical

Name of Medical Group

group chosen for____the contract under

Health Plan

which I am covered. **If the above is not true, I or (person financially responsible for me) will be responsible for all charges related to services provided to me, and will pay in full all such charges. I also understand that any services that are not part of my benefit package are my responsibility.**

____________________ ____________________ ____________

Subscriber's Name *Signature* *Date*