Washington Community High School
Directed Primary Care – Unity Point Junction Medical
Enrollment Form

I am currently enrolled in the WCHS employee health insurance plan and would like to enroll in the Unity Point Junction Medical Directed Primary Care Program.

I understand the following requirements for this program:

- Program benefits will start the first day of the month following submission of this form.
  - Enrollment forms must be submitted by the 20th of the month for benefits to start the 1st day of the following month.
- I, as the employee, must enroll myself in order to enroll any covered dependents.
- All covered individuals who participate in this program must utilize the services at least once per insurance year to remain enrolled in the program.
  - In order to verify utilization, Unity Point will send the district a list of all enrolled members simply stating yes or not as to whether the employee utilized the service during the insurance year.
- There is no out of pocket cost for me and my dependents to participate in this program.

Enrollment Information

Employee Name (First Middle and Last) _____

Email* _____

Phone Number* _____ Home Mobile Work

Street Address* _____

City* _____ State* _____ Zip* _____

Insurance Member #* (found on insurance card) _____

Date of Birth* _____ Sex* (Please circle) Male Female Intersex

Dependent Information

I have family coverage through WCHS and would like to add the following dependents to this program:

Dependent 1

Name (First Middle and Last) _____

Date of Birth* _____ Sex* (Please circle one) Male Female Intersex

Relationship to you* (Circle One) Adult Child

Dependent 2

Name (First Middle and Last) _____

Date of Birth* _____ Sex* (Please circle one) Male Female Intersex

Relationship to you* (Circle One) Adult Child

If you need to add additional dependents, please copy this sheet and add them on additional sheets.

I understand that in order to remain in this program, I and my enrolled dependents must utilize this service at least once during the insurance year.

Employee Signature: _____ **Date:** _____

Please return completed forms to Krystal Ledger in the District Office