**MEC Plan Enrollment Confirmation**
**Phone: 866-995-5944**
**Email: members@healthcare212.com**

**NEW ENROLLMENT**

## PARTICIPANT INFORMATION

| Last Name: | First Name: | MI: | DOB: | Gender: | SSN:(Last 4 digits) |
|---|---|---|---|---|---|
| | | | | | |

**Residence Street Address:**

**COVERAGE LEVEL:**

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I certify that the above information is correct. I authorize my group to make deductions from my earnings necessary to provide my contribution for this coverage and understand that my group is performing this service for my benefit and not as an agent of any insurer. I understand that coverage is not in force until the effective date shown on the Summary Plan Description issued to me. If this form is accepted, this request for participation in my group plan will become part of the agreement between Providence Insurance Partners, LLC and my group.

Fraud Notice - The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information may be guilty of committing a fraudulent insurance act which is a crime and may be subject to criminal prosecution.

Based on the Agreement signed by your group with Providence Insurance Partners, LLC, the monthly rate for MEC$^{TM}$ is as follows:

I have read and understand the above rates, one of which applies to my enrollment based on my enrollment and any additional spouse and/or dependent enrollment as noted in the rates.

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If you have any questions regarding this document, please contact Member Services (Monday - Friday 8am to 6pm) at 866-995-5944.