MyPhysicianPlan
AFFORDABLE HEALTH CARE

employer@myphysicianplan.com

FAX: 443-594-7840

EMPLOYER ENROLLMENT FORM

Organization Details

Organization Name:

Organization website:

Industry:

Type of Business:

Full Address:

Phone Number:

Fax Number:

Email Address:

Contact Person

Contact Person:

Title:

Role:

Email:

Phone:

Mobile:

Employee Details

Total Employees:

Fulltime Employees:

Part-time Employees

Do you have currently insurance coverage? Yes: No:

If "Yes", Name of the provider:

When would you like your coverage to begin:

Where are the employees located? Sate: City:

Note: Please complete the form and email to employer@myphysicianplan.com and fax to: 443-594-7840