

MEMBER ENROLLMENT

NETWORK							
<input type="checkbox"/> OKC <input type="checkbox"/> Rural OK <input type="checkbox"/> Other			Effective Coverage Date: _____				
Please Print MEMBER INFORMATION							
Last name:		First:		Middle:		Primary Member:	
DOB: <small>mm/dd/yyyy</small>		SSN:		Employer:			
<input checked="" type="checkbox"/> Check preferred method of communication:							
<input type="checkbox"/> Office: ()			<input type="checkbox"/> Email:				
<input type="checkbox"/> Home: ()			<input type="checkbox"/> Alternate Email:				
<input type="checkbox"/> Cell: ()							
Race: <input type="checkbox"/> African/African American <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian/Pacific Islander							
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Specified				Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S	
Address 1:				Address 2:			
City:		State:		Zip:		County:	
Plan Selection: <input type="checkbox"/> Primary Care Plan Only <input type="checkbox"/> Primary Care + Specialty Surgical Plan							
I approve Salerno Health to contact me by email for feedback and other health updates. _____ initials <input type="checkbox"/> No							
PLAN SUMMARY OF MONTHLY MEMBER COST							
<i>SalernoHealth Use Only (circle cost)</i>							
Member(s)	1	2	3	4	5	6	7
Primary	\$49	\$49	\$29	\$29	\$12	\$12	\$12
Specialty	\$69	\$69	\$59	\$59	\$39	\$39	\$39
Total Primary Only	\$49	\$98	\$127	\$156	\$168	\$180	\$192
Total Prim+Spec	\$118	\$236	\$324	\$412	\$463	\$514	\$565
Sales Executive:				Referral Source: Check if none: <input type="checkbox"/>			

Salerno Use Only

<input type="checkbox"/> Info Date _____	<input type="checkbox"/> Portability Date _____	<input type="checkbox"/> Termination Date _____
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Salerno Health-OKC LLC Member Agreement

Rights & Responsibilities

1. I acknowledge and understand that I am voluntarily becoming a Salerno Health-OKC LLC, member and that this agreement is not transferable. However the membership plan is portable in the event that I leave my current employer. (Refer to the Salerno Health Member Services Guide for details.)
2. I have read the Salerno Health-OKC LLC Member Services Guide and I have had the opportunity to ask questions and receive answers regarding its content.
3. I acknowledge and understand that this agreement does not provide health insurance coverage, nor is it a contract of insurance and that it provides only the health services specifically described in the Salerno Health-OKC LLC Member Services Guide.
4. I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of the Salerno Health-OKC LLC program, including but not limited to emergency room, hospital and unlisted specialty services and that Salerno Health-OKC LLC will not bill insurance carriers for any services provided by Salerno health-OKC LLC or its providers.
5. I acknowledge and understand that Salerno Health-OKC LLC is being paid through my employer and in the event that such payments are not made, my membership plan will be terminated immediately and services will be provided on a fee-for-service basis.
6. I acknowledge and understand that it is my responsibility to inform my employer of any and all changes to my participation in the Salerno Health-OKC LLC plan, including but not limited to the adding or deleting of dependents and/or spouses/partners.
7. I understand that I have the right to choose my personal health care provider within the **Salerno Health Provider Network**. I understand that I am not assigned to any one Primary Care provider and may utilize one or all Primary Care providers based on convenience and access. I understand that I have the right to receive accurate and easily understood information about Salerno Health-OKC LLC's health care services, health care professionals and health care facilities.
8. I understand that should my employer terminate the Salerno Health-OKC LLC program for any reason that I will be given the option to continue my membership in the plan by successfully completing the membership portability form.
9. I understand that I must abide by the policies and procedures of each Salerno Health-OKC LLC provider.
10. I understand that in the event I am terminated as a patient by a Salerno Health-OKC, LLC, provider, I will no longer qualify as a Salerno Health member. I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care provider(s) or any other staff, which may include complaints about wait times, operating hours, conduct or personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Salerno Health staff or provider(s) staff and to participate in the Salerno Health complaint and grievance process.
11. I understand that even though a treatment is covered as defined by Salerno Health, my physician may determine in the interest of my safety that a procedure should be performed in an inpatient or outpatient facility due to pre-existing complications or comorbidities and would not therefore be covered by my membership.
12. **State insurance insolvency guaranty funds are not available for your use in the event of insolvency or liquidation of this company.**

By my signature below, I agree to the terms outlined in this agreement, for myself and other members listed under my plan. I understand that this is not a contract for health insurance.

Member Signature: _____ Date: _____