

Resurrection Health Care Physicians' Health Insurance Plan Initiative
Affiliation/Eligibility Confirmation



Circle One GROUP or INDIVIDUAL

IF Applicant is member of a GROUP:

Name of Group: _____

Name of Group's Physician contact relative to this
health insurance plan: _____

Name of Group's Financial Principle: _____

Name of Applicant
Address

Resurrection Hospital Affiliation

Affiliated Since

Month/Year

Effective Date Desired

I hereby confirm that the above mentioned applicant is currently affiliated with Resurrection Health Care or is an employee of a Resurrection Health Care affiliated group. As such, they are eligible to participate in the PBT Resurrection Health Care Physicians Health Care Plan.

Authorized Signature:

Resurrection Medical Staff Physicians

Date

Steering Committee Chair

Please Print Name