Corporate Enrollment Form

Company Name: _____

Company Contact/Title: _____

Additional Contact/Title
(Person to receive invoice): _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Email: _____

<u>Coverage (employer responsibility to Atlas MD)</u>

Membership: _____%

Labs: _____%

Medications: _____%

Misc Charges _____%

Preferred Payment Method:

- ○ **Monthly Check**
- ○ **Monthly Credit/Card** **Auto-Debit Enabled: 5th, 10th, 15th, 20th, 25th (circle)**
  (You may call to provide this billing information over the phone for security purposes)