



**ENROLLMENT FORM**

\*Name: \_\_\_\_\_

\*Sex: \_\_\_\_\_ \*DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Address: \_\_\_\_\_

Address/Apt./Suite: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_

\*Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

\*E-mail: \_\_\_\_\_

\*Type of Coverage: \_\_\_ Individual or \_\_\_ Family

Annual Cost: \$85.00 Individual or \$95.00 Family

Fields marked by a\* are required entries.

Method of Payment:

\_\_\_\_\_ Check

\_\_\_\_\_ Visa

\_\_\_\_\_ MasterCard

\_\_\_\_\_ American Express

\_\_\_\_\_  
Credit Card #

\_\_\_\_\_  
Exp. date

\_\_\_\_\_  
Signature (required for all forms of payment)

\*Family members eligible for coverage are your spouse, children age 21 and under living with you or children age 25 and under that are full-time students, and parents living with you.

Coverage will begin the first of the month following receipt of this enrollment form and will continue for one year.

Please send enrollment form to:

Mass Benefits Consultants, Inc.  
P.O. Box 828  
7212 Poplar Street  
Annandale, VA 22003