



## EverMed Enrollment Form

Effective Date	Broker	Total Enrolled	
Employer	Employer TPA	Employer Insurance	
<b>Complete the information below for enrollment with EverMed DPC</b>			
Employee Name		Birthdate	
Address			
City, State, Zip			
Phone			
Email <small>(Required)</small>			
Spouse's Name		Birthdate	
Phone			
Email			
<b>Dependents</b>			
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	

\*Add additional dependents on the back of this form

**List Any Additional Dependents**

Name		Birthdate	
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	
Name		Birthdate	

**\* Review the Retainer Medical Agreement, sign and return completed forms to your Employer for enrollment with EverMed DPC.**