CITY OF CORPUS CHRISTI WELLNESS CLINIC

ELIGIBILTY RECORD

Plan Year 2024-2025

Name: _____ **Department:** _____

Employee ID: _____ **Work Status:**_____

Date of Hire: _____ **Date of Birth:** _____

Eligible From: _____ **Eligible To:** _____

(*Eligibility is effective for 30 days*)

To enroll dependents, please list below and provide documentation.

(*Dependent documentation is required for their access to the Wellness Clinic.*)

☐ **Check if NO DEPENDENTS**

	DEPENDENT'S NAME (*As it appears on Social Security Card*)	**RELATIONSHIP**	**DATE OF BIRTH**
1			
2			
3			
4			
5			

Please acknowledge your understanding of the following:

☒ I understand that I am responsible for payment of all services for myself and my dependents at the time of service. The fee to access the clinic is $20 per person. Any lab work deemed necessary will be an additional $15. I understand that I must complete a new eligibility form to gain access to the Wellness Clinic after the plan year has expired.

☒ I understand that my and my dependents eligibility is only valid at the Wellness Clinic for 30 days beginning on the date of signature on this form.

☒ I understand that I must complete a new eligibility form to gain access to the Wellness Clinic after the **plan year** has expired.

_____ _____

Employee Signature **Date**

_____ _____

Human Resource Authorization By: **Date**