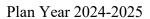
CITY OF CORPUS CHRISTI WELLNESS CLINIC

ELIGIBILTY RECORD





Name: Employee ID: Date of Hire: Eligible From:		Department: Work Status: Date of Birth: Eligible To:					
				(Eligi	ibility is effective for 30 days)		
					nroll dependents, please list below and provendent documentation is required for their access to Check if NO DEPENDENTS		
					DEPENDENT'S NAME (As it appears on Social Security Card)	RELATIONSHIP	DATE OF BIRTH
1	(15 it appears on Social Security Cara)						
2							
3							
4							
5							
Pleas	se acknowledge your understanding of the fol	llowing:					
	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.						
X	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.						
X	I understand that I must complete a new elithe plan year has expired.	gibility form to gain access to	the Wellness Clinic after				
Employee Signature		- Date					
Human Resource Authorization By:		Date					