CITY OF CORPUS CHRISTI WELLNESS CLINIC

# ELIGIBILTY RECORD

Plan Year 2025-2026

**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**