



MOA INSURANCE REQUEST INFORMATION FORM

If you haven't already requested and/or received information regarding the various options through the MOA/BCBSM health care program, please submit this form to have information sent to you.

Date

Your Name

Are you a *Member, Spouse, or Employee*?

If a member, are you *Practicing or Retired*?

Are you on Medicare?

Practice Name

Practice Address

City

State

Zip

County

Clinic Hours

Phone

Fax

Best Person to Contact

Best time to call

Total Number of Employees/Physicians on payroll

Number of Employees/Physician currently enrolled in health care plan

Please fax or email this form to Devona Jameson at:

Tel: 1-800-657-1556

Fax: 517-347-1566

Email: djameson@mi-osteopathic.org