



Corporate Enrollment Form

Company Name: _____

Company Contact/Title: _____

Additional Contact/Title
(Person to receive invoice): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Coverage (employer responsibility to Atlas MD)

Membership: _____%

Labs: _____%

Medications: _____%

Misc. Charges _____%

Preferred Payment Method:

Monthly Check

Monthly Credit/Card

Auto-Debit Enabled: 5th, 10th, 15th, 20th, 25th (circle)

(You may call to provide this billing information for security purposes)