BioCore Therapeutics
wellness backed by science

EMPLOYER ENROLLMENT FORM

The information requested on this application is necessary for purposes of processing your request for group wellness clinical services.

Effective date ____/____/____

EMPLOYER INFORMATION

Employer Legal Name	Group Contact Name	Date Prepared

DBA (if applicable)

Address	City	State	Zip Code

Phone	Fax	E-mail Address

Address of Organization's Headquarters	City	State	Zip Code

NAICS Code and SIC Code	# of Locations	Tax Id #	Coverage Effective Date

Are all of the employees in your group associated with the same EIN/TIN? YES NO	If you do not have a federal EIN/TIN, are you a foreign-owned organization? ☐Yes ☐No

Total Number of Eligible Employees	Eligible Employees ☐Full-Time ☐Part-Time/Contractors	Enrollment Length 3 Month 6 Month 12 Month

Is there a single address where all Coordination of Benefits issues and questions should be directed? ☐Yes ☐No
If yes, please provide that address (if different from address of headquarters address).

Address	Phone	Fax

City	State	Zip Code

Type of Organization (check all that apply):

☐State government ☐Publicly traded corporation ☐Church group ☐Other

☐Local government ☐Privately held corporation ☐Non-profit

Type of eligible individuals (check one): ☐ Employee ☐ Family

Group Size – Total Number of Full and/or Part-time Employees/Family (check one): Please select the largest applicable category. In making your selection, consider your organization/company's total number of employees world wide, regardless of location or eligibility for health care coverage.

☐2-99 full and/or part-time employees, contractors and family

☐100 or more full and/or part-time employees, contractors and family

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Company name: _____

BILLING INFORMATION

Billing Contact			☐ Same as Group Contact
Address	City	State	Zip Code
Phone	Fax	E-Mail Address	

SERVICE SELECTION

For additional benefit selection information, refer to the attached plan summaries. Please review the summaries for all plans purchased and make your selections in the chart below.

Business Offering:	Plan Type Check Box:	BioCore Therapeutics Offerings:
☐ Wellness Services ☐ Weight-Loss	☐ FSA ☐ HSA ☐ Employer Pay * Certain Minimum Benefits Apply. ☐ Employee Pay ☐ Other_____	☐ Weight Loss Medication ☐ Peptides ☐ Diet Plans ☐ Styku Scanning ☐ Emerald Laser Treatment

BioCore Therapeutics does not bill Major Medical Plans for services. The clinic can and will accept HSA, FSA cards and can send out a bill for services for employee reimbursement

Fees collected by: ☐Employer deduction from employee paycheck and bill employer ☐ BioCore Therapeutics bills the employee

ADMINISTRATIVE

Enrollment Period From	Enrollment Period To	Ongoing Enrollment Method ☐ Paper Application ☐ Auto Renew
Account Structure We can set up separate bill groups when you require premium to be allocated and reconciled by division or department. Do you require separate bill groups? ☐Yes ☐No		
Bill Group Name		
Bill Group Name		
Bill Group Name		

Payment Date

Choose Your Accumulation type: ☐Calendar Month (Customary; January 1 -December 1) ☐From Date of Sevice

If Date of Service, select the start month and day:_____

☐ JAN	☐ FEB	☐ MAR	☐ APR	☐ MAY	☐ JUN	☐ JUL	☐ AUG	☐ SEP	☐ OCT	☐ NOV	☐ DEC

EMPLOYER ENROLLMENT FORM

Company name:

EMPLOYER INFORMATION

Employer acknowledges that this service is a fee for service clinic, and is not health insurance or a benefit plan. Employer agrees to the monthly billing on Final Monthly Services Worksheet

Group represents and warrants that Group complies with eligibility requirements, pursuant to minimum employee enrollment.

I understand and agree, on behalf of the employer, that the statements in this application are true and complete to the best of my knowledge and belief.

Any intentional material misstatement or omission of information made on this application will be considered a misrepresentation and may be the basis of price adjustments.

Signed this _____ day of _____	City	State
By (Signature of Authorized Company Officer X		Title