SOLIDARITY HEALTH NETWORK
Experts in Benefit Administration
Service Since 1989

SHN TELEMEDICINE BENEFIT APPLICATION

Account Holder Information

Name: _____ Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number #: _____ Date of Birth: _____/_____/_____
Month Day Year

Email Address:_____

Dependent Information

Name: _____Social Security Number _____

Date of Birth: _____/_____/_____ Email Address:_____
Month Day Year

Name: _____Social Security Number _____

Date of Birth: _____/_____/_____ Email Address:_____
Month Day Year

Name: _____Social Security Number _____

Date of Birth: _____/_____/_____ Email Address:_____
Month Day Year

Name: _____Social Security Number _____

Date of Birth: _____/_____/_____ Email Address:_____
Month Day Year

Name: _____Social Security Number _____

Date of Birth: _____/_____/_____ Email Address:_____
Month Day Year

Name: _____Social Security Number _____

Date of Birth: _____/_____/_____ Email Address:_____
Month Day Year

Additional Dependents Can be added on a separate sheet of paper. 8 members in a family is the maximum

Requested Effective Date of Coverage: _____/1st /2020

Monthly Payment of $7 single/$11 family_____ One Time Annual Payment of $60 single/$100 family_____

Member Signature (Required)	**Date**