

HCO Enrollment Form

I have received information about these Health Care Organizations [Employer to insert names of HCOs offered]

A. _____

B. _____

C. _____

D. _____

I want to enroll in an HCO for my medical care for any work-related injury or illness.

(Write in the name of the HCO you have chosen)

The physician who treats me for non-work injuries,

_____, is in one of the HCOs listed above:

(name of physician)

(name of HCO, if different than the HCO you have chosen above)

I do not want to enroll in an HCO and want to choose my personal physician or chiropractor for any work-related injury or illness.

Name of Employee

Signature

Date

If you have chosen an HCO above, please fill in this box:

Date of Birth _____ Social Security Number _____

Sex M F Occupation _____

Race/: White Latino Black Asian or Pacific Islander
 Other (specify)

The language you feel most comfortable speaking:

English Spanish Chinese Tagalog Other:

(specify)