Economy Plan- Enrollment Form

This plan is administered by Sav-RX to offer a pharmacy benefit at a low monthly premium.

Participant Name: ________________________________ D.O.B.: ___/ ___/ ___
Address: ____
City: ________________ State: ____ Zip: _____Telephone # (____) ___________
Email Address: ____
Spouse Name: ________________________________ D.O.B.: ____/ ____/____
Dependent Name: ________________________________ D.O.B.: ____/ ____/____
Dependent Name: ________________________________ D.O.B.: ____/ ____/____
Dependent Name: ________________________________ D.O.B.: ____/ ____/____

Member Name: ____
Membership #: ____________________ Local #:________

Monthly Premium:

_____ Single $6.00
_____ Participant + Spouse $12.00
_____ Participant + 1 Dependent $12.00
_____ Participant Family $18.00

Coverage Start Month: ___________ Coverage End Month: ___________

Number of Months: # ___________ Total Paid: $___________

Please make checks payable to: MROC
Please remit form & payment to: MROC
C/O Melissa Hendricker
1 N Old State Capitol Plaza, Suite 525
Springfield, IL 62701

***Note: If you are a Medicare/Medicaid eligible participant, certain medications not covered by Medicare/Medicaid may be covered by this plan. ***

Participant Signature: ______________________________ **Date:**________________