

SCHC
SOUTH CAROLINA
 HEALTH COOPERATIVE
A New Approach to Healthcare

AUTHORIZATION FORM

Any incomplete or illegible form will delay processing
 Use Ink ONLY.

COMPANY / GROUP NAME				
EMPLOYEE INFORMATION (Please print)				
First Name	MI	Last Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Street Address (If different than employee)	Apt #	City	State	Zip
Social Security Number	Birth Date / /		# Hours Worked Per Week	
EMPLOYEE SIGNATURE				
<p>AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any health care professional or entity to give the S.C. Health Co Op and their health carriers any and all records or information pertaining to medical history or services rendered to me for any administrative purpose, including evaluation of a form or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security Number for purpose of identification. The information provided by me on this form is true and accurate. I understand and agree that any omissions or incorrect statements knowingly made by me on this form may invalidate my coverage, subject to time limits on certain defenses. I realize any false statements, omissions, and/or material misrepresentations regarding any information requested on this form, could cause an otherwise invalid claim to be denied and/or cause the health coverage, if issued, to be cancelled as never effective.</p>				
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Employee Signature (REQUIRED)			Date (REQUIRED)	

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