



**SOUTH CAROLINA  
HEALTH COOPERATIVE**  
*A new approach to healthcare*

**Membership Application**

Company Name			
Physical Address	City	State	Zip Code
Counties Served (Please list all counties with offices or operations.)			County Where Headquarters Located
Main Nature of Business (i.e., Realty, Florist, Contractor, etc.)			
Contact Person	Phone Number	Fax	Email
	( ) -	( ) -	
Business Type (please check one)			Creation Date
Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> S Corporation <input type="checkbox"/> C Corporation <input type="checkbox"/> LLC <input type="checkbox"/>			

\*Please attach Articles of Incorporation, Partnership Agreement, and Articles of Organization where applicable

Previous Year's Sales in Dollars										Total Assets										Projected Net Income									

\*Please attach most current quarterly financial statement, or Tax Form 1099 for a sole proprietorship, Tax form 1065 for a partnership or a LLC, Tax form 1120 for a C corporation, Tax form 1120S for a S corporation

Total Employees on Payroll \_\_\_\_\_ Total Employees Seeking Health Insurance Through Company \_\_\_\_\_

- Does your business currently have group health insurance?.....  YES  NO  
\*If yes, please attach a copy of the most recent bill for the group.
- Did your business ever have group health insurance for your business?.....  YES  NO  
\*If yes, when? \_\_\_\_\_
- Does your business understand that this health insurance program requires a 5 year commitment.....  YES  NO
- Does your business have life insurance? If so, how much per employee?.....  YES  NO
- Does your business have dental insurance? If so, what is the cost per employee?.....  YES  NO
- Does your business have vision insurance? If so, what is the cost per employee?.....  YES  NO
- Does your business have voluntary life insurance? If so, what is the cost per employee?.....  YES  NO
- Does your business have workman compensation insurance?.....  YES  NO
- How did you come to know about The South Carolina Health Cooperative?

Agent  Newspaper  Radio  Television  Recommendation

Agent's Name	Date of Meeting	Date of Submission	Initials
	/ /	/ /	
	/ /	/ /	

I hereby certify that to the best of my knowledge and belief all of the information on this form is true and correct. I understand that a failure to report on this form completely and accurately may result in a delay of consideration or denial of membership. I also understand that this application will be consider at the next open enrollment for The South Carolina Health Cooperative, which must occur in the next year.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_

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