
# Enrollment Form

*Please Print*

* Name:_____

* Sex:_____ * Date of Birth:_____/____/_____

* Street:_____

* Apt/Suite:_____

* City:_____ *State:_____

* Zip: _____ Phone:_____/_____-_____

* e-mail:_____

Federal Agency:_____

Fields marked by a * are required entries

**$95.00 per year**

Method Of Payment:

☐ Check

☐ Visa

☐ MasterCard

☐ American Express

_____ _____
Credit Card Number Exp. Date

_____ _____
Signature Date Signed

Coverage will begin the first of the month following receipt of this enrollment form and will continue for one year.

Please mail Enrollment Form to:

Mass Benefits Consultants
PO Box 828
Annandale, VA 22003-0828

Questions? Call 1-800-221-3083