



## MOA INSURANCE REQUEST INFORMATION FORM

*If you haven't already requested and/or received information regarding the various options through the MOA/BCBSM health care program, please submit this form to have information sent to you.*

Date

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Your Name

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Are you a *Member, Spouse, or Employee*?

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If a member, are you *Practicing or Retired*?

Are you on Medicare?

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Practice Name

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Practice Address

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City

State

Zip

---

County

Clinic Hours

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Phone

Fax

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Best Person to Contact

Best time to call

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Total Number of Employees/Physicians on payroll

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Number of Employees/Physician currently enrolled in health care plan

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***Please fax or email this form to LaTasha Richardson at MOA:***

***Tel: 1-800-657-1556***

***Fax: 517-347-1566***

***Email: LaTasha@moa-do.com***