Anglican Communion Network
Medical Program Questionnaire

1. Do you currently have medical insurance? ☐ **Yes** ☐ **No**

2. If applicable, does this plan adequately cover you and/or your family? ☐ **Yes** ☐ **No**

3. Would you be interested in acquiring medical coverage through the Anglican Communion Network? ☐ **Yes** ☐ **No**

4. Is cost or comprehensive coverage more important to you and/or your family? ☐ **Cost** ☐ **Coverage**

5. Would you like prescription drug coverage, dental, and/or vision coverage to be offered? ☐ **Yes** ☐ **No**

6. What type of benefits or additional coverage would you like to have included in your program?

_____

_____

7. Please provide any additional comments that you might have: _____

_____

_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Spouse's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____