



Workplace Wellness Enrollment Form
(Please type or print)

Employee Information

Name: _____

Address: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Spouse Information (if applicable):

Name: _____ Date of Birth: _____

Social Security Number: _____ Email Address: _____

Cell Phone: _____ Work Phone: _____

Dependent Information (if applicable):

Name: _____ Date of Birth: _____

Social Security Number: _____ Email Address: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Date of Birth: _____

Social Security Number: _____ Email Address: _____

Cell Phone: _____ Work Phone: _____

Name: _____ Date of Birth: _____

Social Security Number: _____ Email Address: _____

Cell Phone: _____ Work Phone: _____

For additional dependents, check this box and attach an additional page.

I understand that this demographic information has been collected by Clinical Outcomes Group, Inc. as part of their contract with my Employer. By signing below, I hereby certify that the information provided on this form is true and correct. I understand that it is my responsibility to notify Clinical Outcomes Group, Inc. of any changes to this information within 30 days of such change. All individuals included on this form will be considered to be enrolled in the Clinical Outcomes Group, Inc. Workplace Wellness Program according to the contract they have signed with my Employer.

Employee Signature

Date

COGI Use Only

Employer: _____ Entered: _____

Contract Term: _____