

**myENROLLMENT ACCOUNT
REQUEST FORM**



Please complete the fields below and return to SHPENROLL@SanfordHealth.org.

Date	
Applicant Name (Please Print)	Group Name
Work Email Address	Cell Phone (Note: PIN will be last 4 digits of phone)
Address	
City	State
Zip	County
<input type="checkbox"/> HR Representative <input type="checkbox"/> Agent	