

Member Enrollment Form

MEMBER INFORMATION

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

DELIVERY ADDRESS (Please use current address)

Address 1 (Street Address)		
Address 2 (Apartment #, Suite #, Etc)		
City	State	Zip
Home Phone	Work Phone (Include area code)	
Email Address (Optional)		

SPOUSE INFORMATION

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

INSURANCE INFORMATION

Member ID	Group ID (On your Member ID Card [If Applicable])
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PAYMENT OPTIONS (Filing purposes only. Payments due at time of order.)

Please indicate your choice by checking the appropriate box.

CREDIT CARD

Name On Card

Card Number

Expiration Date (MM / YY)

CHECK / MONEY ORDER

Submit your check or money order at time of order.

DEPENDANT INFORMATION

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

First Name	MI	Last Name
Date of Birth (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Please sign and date below to complete the enrollment.

I certify that the information on this form is correct, and authorize release of information regarding my medical and prescription drug history to the program sponsor of the prescription drug program.

Member's Signature _____

Date _____