MEMBER CARD REGISTRATION FORM

(Please PRINT when filling out this form carefully and completely.) If Indigent complete section 1-10 and 20 only)

1. Last Name:	First Name	Middle Name:	
2. Street Address:	District:	P.O.Box#:	Postal Code:
3. Gender: Male Female	4. Birth Date (dd/mm/yyyy):	5. Email Address:	
6. Home Telephone:	7. Work Telephone:	8. Cell Phone:	
9. Marital Status (please check one): Single	Married	Divorced	Widowed Separated
10. Employer or Government Department Name (if applicable):		11. Employer Tel #:	

Identify Dependents by completing items 13 through 17 (continue on a seperate sheet if required). Only dependents listed below will be covered. (Omit if dependent coverage is NOT desired.)

12. Full Name(s) of Dependents	13. Relationship (Spouse / Child)	14. Gender (m/f)	15. Birth Date*	18. Other Insurance: YES**	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐

If child is aged 18 and less than 23, attach full time student information

19. Spouse's Employer and Complete Address:

20. Dependent Health Plan Provider Information

List Name(s) of Dependents	Insurance Company Name, Address & Phone #	Policy and Identification Number	Coverage Type: Medical or Dental	Effective Date of Coverage

21. Next of Kin: Name: Phone #: PO Box:

Signature________________________ Date ________________________

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