



## 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 separate 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	
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

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

19. Spouse's Employer and Complete Address:
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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:
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Signature \_\_\_\_\_ Date \_\_\_\_\_