



First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone

Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Cell ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Best Time to Contact \_\_\_\_\_

E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female

Are You Retired?  Yes  No

Employer (if applicable) \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

Additional Family Members (if applicable)

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female

Insurance Company (if applicable) \_\_\_\_\_

Insurance ID Number \_\_\_\_\_

Policy or Group Number \_\_\_\_\_

Customer Service Telephone Number ( ) \_\_\_\_\_

Signature

Date

Individual Membership -- \$79.95  Family Membership (2 people) -- \$129.00  Family Membership (3-6 people) -- \$179.00

Check enclosed

Please charge my credit card  MasterCard  Visa  American Express

*(Please make checks payable to "Health Care Advocates of Indiana")*

Card Number \_\_\_\_\_

Expires \_\_\_\_\_