

Enrollment Form (please print)

To get your LifeMed Smart Card, fill out and mail this form today!

Please print and complete the information below (one form needed for each family member).

CARDHOLDER INFORMATION (as listed on insurance card)

Name (Last, First, MI) _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Cell Phone () _____
 Primary Care Physician _____
 Birthdate (MM/DD/YYYY) _____
 Sex _____ Marital Status _____
 Social Security # _____

EMPLOYER INFORMATION

Employer Name _____
 Work Phone () _____
 Check one: Full time Part time Self Employed Retired

EMERGENCY CONTACT

Name (Last, First, MI) _____
 Home Phone () _____
 Cell Phone () _____
 Relationship to Patient _____

GUARANTOR INFORMATION

(Person responsible for patient account) Check if same as patient

Name (Last, First, MI) _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Cell Phone () _____
 Birthdate (MM/DD/YYYY) _____
 Sex _____ Marital Status _____
 Social Security # _____
 Employer Name _____
 Work Phone () _____
 Check one: Full time Part time Self Employed Retired
 Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance

Claims Address/PO Box _____
 City _____ State _____ Zip _____
 Claims Phone () _____ Fax () _____
 Subscriber Name Check if same as patient
 Name (Last, First, MI) _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Cell Phone () _____
 Birthdate (MM/DD/YYYY) _____
 Sex _____ Marital Status _____
 Social Security # _____
 Employer Name _____
 Work Phone () _____
 Check one: Full time Part time Self Employed Retired
 Relationship to Patient _____
 Policy # _____
 Group # _____

Secondary Insurance

Claims Address/PO Box _____
 City _____ State _____ Zip _____
 Claims Phone () _____ Fax () _____
 Subscriber Name Check if same as patient
 Name (Last, First, MI) _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Cell Phone () _____
 Birthdate (MM/DD/YYYY) _____
 Sex _____ Marital Status _____
 Employer Name _____
 Work Phone () _____
 Check one: Full time Part time Self Employed Retired
 Social Security # _____
 Relationship to Patient _____
 Policy # _____
 Group # _____