DocuBank Enrollment Instructions

1. Complete Enrollment Form
Complete the enrollment form on page 2 of this PDF.

2. Submit Enrollment Forms and Docs to DocuBank by Email, Fax, or Mail

Email

1. Scan Enrollment Form and signed healthcare directives. Save the Enrollment Form as one PDF file and the documents as a separate file.
2. Email files to DocuBank with the subject line "Enrollments for *your last name*." Make sure the total size of the attachments does not exceed 10 MB.

Email:
- Enrolls@docubank.com

Fax:
- 610-667-1483

Mail:
- DocuBank
- PO Box 325
- Narberth PA 19072

Fax

1. Fax your documents with a cover page and Enrollment Form to the number above.

Mail

1. Photocopy your signed healthcare directives. Please do not fold or staple documents.
2. Mail your healthcare directives and completed Enrollment Form to the address above.
3. Make checks payable to DocuBank. Please mail in a flat envelope. (Your documents will scan more clearly this way!)

Documents Stored on Emergency Card

Advanced Medical Directives	Healthcare Power of Attorney	Living Will
HIPAA Release Authorization	Directives to Physician	Medication List
Funeral Arrangements	Hospitalization Visitation Form	Organ Donor Forms

Updating Your Documents
When you revise your documents, please send DocuBank a new copy so we can update your documents on file.

Email: updates@docubank.com

Fax: 610-667-1483

Mail:
DocuBank
Attention: Replacements
PO Box 325
Narberth, PA 19072

DocuBank® Healthcare Directive Registry Enrollment Form

A. Member Information Information in **BOLD** appears on your card. **Email address is required for online account access.*

Prefix: **Name**:	Home Phone:
Address:	Work Phone:
City, State, Zip:	Email Address*:
	DOB *(optional):*
Caregiver Help	

B. Service Selection ☐ One Year ~~**$45**~~ **$20** *(56% discount)* ☐ Five Years ~~**$145**~~ **$60** *(59% discount)*

C. Payment Method ☐ Credit Card ☐ Check *(payable to DocuBank)*

Credit Card Number _____ Exp Date _____

Name on Credit Card _____ Card Type _____

D. Emergency Contacts *(Optional) If information is not available now you can call us to update after you receive your card.*

First Contact **Physician** (*if fax# is provided, a fax may be sent to Dr.)

Name:	Relationship:	Name:	
Home #:	**Work #:**	Phone:	Fax*:
Cell #:	Email:	**First Contact Note:**	

Second Contact **Third Contact**

Name:	Relationship:	Name:	Relationship:
Home #:	Work #:	Home #:	Work #:
Cell #:	Email:	Cell #:	Email:

E. Optional Card Info *Please number up to 4 selections. (All selections may not fit on your card.)*

Allergies ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Peanuts ☐_____ ☐_____ ☐_____

Permanent Medical Conditions *(Do **not** list medications here. See section F.)*

☐ Alzheimer's ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ Cancer survivor_____(type) ☐ Stroke history ☐_____ ☐_____

Card Note *(45 char. max)* _____

F. Medication List *(Optional) You can store a list of your medications. Because medications may change frequently, there is an additional fee at time of renewal.* **Is a Medication List (signed and dated) included**? ☐ **Yes** ☐ **No**

G. Member Statement I have completed an advance directive document(s) (e.g. health care power of attorney) of my own free will and have chosen to enroll in DocuBank to help make my document(s) available when requested. To ensure prompt access, I authorize that my document(s), emergency contact and health information stored with DocuBank be accessible to anyone who provides the member number and PIN on my card. I will notify DocuBank promptly of changes in any of my stored information, and also of the revocation or replacement of my document(s). I understand that DocuBank is not responsible for the validity or accuracy of any information stored by DocuBank, including the health information that also appears on my card. I understand that: by accepting my card I have verified and confirmed the accuracy of all information on the card before carrying it; by providing a fax number for my physician, I am granting DocuBank permission to fax an enrollment notification enabling this physician to obtain my directives; that if I provide an email address for my emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with my member information; that DocuBank does not provide legal advice; and that I may cancel this service in writing at any time by written request to DocuBank.

Optional Alerts: Check 1 or none:

☐ I elect to have DocuBank send an email notice to my emergency contacts upon my enrollment and whenever my documents are requested.

☐ I elect to have DocuBank send an email notice to my emergency contacts upon my enrollment only.

Signature: _____ Date: _____