ENROLLMENT FORM

PROTECTING YOUR FAMILY WITH ANY OF THESE PLANS IS SIMPLE: Follow the instructions at the bottom of this page.

SERVICE SELECTION

(Select only one)

SNAP

SPECIAL NEEDS ADULTS

◯ **1 year** ◯ **5 years**

REFERRAL SOURCE *(Optional: Name of firm and/or professional that referred you to DocuBank)*

Firm/Provider Name: ______________________________

MEMBER INFORMATION

Name: ______________________________ **DOB:** *(MM/DD/YY)* ______ / ______ / ______

CONTACT INFO

Address: ______________________ **City:** ______________________ **State:** ____ **Zip:** ________

Home #: ______________ **Cell #:** ______________ **Email:** ______________________

ALLERGIES: ◯**Penicillin** ◯**Sulfa** ◯**Latex** ◯**Peanuts** ◯ ______________ ◯ ______________

PERMANENT MEDICAL CONDITIONS *(Do not list medications)*

◯**Diabetes** ◯ ______________ ◯ ______________ ◯ ______________

Card Note *(45 char. max)* ______________________________

EMERGENCY CONTACTS *(optional) If information is not available now, you can update it when you receive your card.*

1ST CONTACT

Name: ______________ **Relationship:** ______________

Home #: ______________ **Work #:** ______________

Cell #: ______________ **Email:** ______________

DOCTOR *(Primary Care) If fax # is given, doctor may receive fax with access information*

Name: ______________________________

Phone #: ______________ **Fax #:** ______________

1ST CONTACT Note: ______________________________

2ND CONTACT

Name: ______________ **Relationship:** ______________

Home #: ______________ **Work #:** ______________

Cell #: ______________ **Email:** ______________

3RD CONTACT

Name: ______________ **Relationship:** ______________

Home #: ______________ **Work #:** ______________

Cell #: ______________ **Email:** ______________

ADDITIONAL DOCUMENTS STORED *(Notation will appear on member's card)*

◯ **Medication List**

MEMBER STATEMENT: I have chosen to enroll myself or my ward, in DocuBank to help make their emergency information available promptly. To ensure prompt access, I authorize that my, or my child or ward's, document(s), emergency contact and health information stored with DocuBank be accessible to anyone who provides the member number and PIN on the DocuBank member card. All advance directives have been completed of my own free will and I will notify DocuBank promptly of changes in any of the stored information, and also of the revocation or replacement of any 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 the member card; by accepting a card I have verified and confirmed the accuracy of all information on the card before carrying or distributing it; I am granting DocuBank permission to alert my contacts as indicated on this form; if I provide an email or cell phone for the emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with member information. I understand that my DocuBank membership includes the optional use of the DocuBank SAFE, which provides online access to my personal documents. I understand that DocuBank does not provide legal advice; and that I may cancel this service in writing at any time by written request to DocuBank.

SIGNATURE: ______________________________ **DATE:** ______________

(Adult enrollee or parent/legal guardian)

TO ENROLL: Send this completed form, your payment and the relevant emergency documents as described for each service *(e.g. HIPAA Release, Health Care Power of Attorney, Guardianship Forms, and more)*. You can also include an additional Emergency Information Form and Medication List, which are available at **docubank.com/forms**.

MAIL TO:
DocuBank
P.O. Box 629
Springfield PA 19064

EMAIL TO:
joindocubank@docubank.com

FAX TO:
610-667-1483

QUESTIONS?
Call 1-866-829-0993 or visit DOCUBANK.COM