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)

1 year $55 5 years $175

DocuBank ICE
COLLEGE STUDENTS
◯ **1 year** ◯ **5 years**

Minors Matter
CHILDREN UNDER 18
◯ **1 year** ◯ **5 years**

SNAP
SPECIAL NEEDS ADULTS
◯ **1 year** ◯ **5 years**

PROVIDED THROUGH *(Name of firm and/or professional providing this membership)*

Firm Name: _____ **Provider:** _____

MEMBER INFORMATION *(The name that will appear on the card. For ICE or Minors Matter, this is the child's info)*

Name: _____ **Sex:** _____ **DOB:** *(MM/YY)* _____ / _____

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

PERMANENT MEDICAL CONDITIONS *(Do not list medications)*

◯ **Diabetes** ◯ _____ ◯ _____ ◯ _____

Card Note *(45 char. max)* _____

MAILING ADDRESS *(Please provide address of member's parent/guardian)*

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

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** ◯ **HIPAA Release** *(ICE only)* ◯ **Health Insurance Information** *(Minors Matter only)*

MEMBER STATEMENT: I have chosen to enroll myself, or minor child or 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 address 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.

OPTIONAL SAFE UPLOAD

◯ I authorize my DocuBank Provider (above) to upload my estate planning and other documents to my DocuBank SAFE.

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 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 325
Narberth PA 19072

EMAIL TO:
joindocubank@docubank.com

FAX TO:
610-667-1483

QUESTIONS?
CALL 1-866-DOCUBANK or go to DOCUBANK.COM