



# GSH Wellness Matters Clinic

## Individual Membership Application

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Email Address: \_\_\_\_\_

Current Medical Insurance Carrier: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Rates:** (Mark quantity of participants in each category)

Monthly Membership:

\_\_\_\_\_ 1-24(\$30/mth) \_\_\_\_\_ 25-64(\$60/mth) \_\_\_\_\_ 65+(\$75/mth)

**Membership fees will be deducted from your designated checking account or credit card account on the 15<sup>th</sup> of each month (i.e. January membership fee will be deducted on January 15<sup>th</sup>, February membership fee will be deducted on February 15<sup>th</sup>, etc.). Authorization form must be completed with this application.**

Family Members: (Above name will be considered primary participant)

Participant 2: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant 3: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant 4: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant 5: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If more space is needed, please list name and DOB on the back of this page.

### Membership Fees

Total Monthly Membership Fee: \$ \_\_\_\_\_ per Month (Use calculation sheet on back)

Start Date of Membership: \_\_\_\_\_

**Primary Member Signature:** \_\_\_\_\_ Date Signed: \_\_\_\_\_

Application received by: \_\_\_\_\_ Received Date: \_\_\_\_\_

**Monthly Membership Fee Calculation:**

1-24: \_\_\_\_\_ x \$30 = \$ \_\_\_\_\_

25-64: \_\_\_\_\_ x \$60 = \$ \_\_\_\_\_

65+: \_\_\_\_\_ x \$75 = \$ \_\_\_\_\_

Additional Family Members BEYOND 5: \$10/mth. \$ \_\_\_\_\_

Participant 6: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant 7: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant 8: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

TOTAL MONTHLY MEMBERSHIP FEE: \$ \_\_\_\_\_ (\$150 for family coverage up to 5 members)

**Initial Required Payment:**

1-24: \_\_\_\_\_ X \_\_\_\_\_ (# days until end of current month) X \$1/day (daily rate) = \$ \_\_\_\_\_

25-64: \_\_\_\_\_ X \_\_\_\_\_ (# days until end of current month) X \$2/day (daily rate) = \$ \_\_\_\_\_

65+: \_\_\_\_\_ X \_\_\_\_\_ (# days until end of current month) X \$2.5/day (daily rate) = \$ \_\_\_\_\_

**Sub-Total:** \$ \_\_\_\_\_

**One-Time Application Fee:** \$50.00

**TOTAL Initial Payment Due(\*):** \$ \_\_\_\_\_

**(\*) Initial Payment must be made by check or cash.**

**PRIMARY MEMBER MUST COMPLETE A CREDIT CARD/BANK DRAFT PERMISSION FORM**