CHRISTIAN HEALTHCARE CENTERS®

MEMBERSHIP APPLICATION FORM

PLEASE PRINT LEGIBLY. THANK YOU.

FOR OFFICE USE ONLY:
CERBO _____
HINT _____

REGISTRATION TYPE:

☐ INDIVIDUAL ☐ FAMILY ☐ SENIOR (65+) ☐ FULL-TIME UNDERGRADUATE COLLEGE STUDENT (ID REQUIRED)

☐ EMPLOYER GROUP — IF YES, NAME:

LOCATION: ☐ GRAND RAPIDS ☐ NEWAYGO ☐ HOLLAND

RACE: ☐ WHITE ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ OTHER ☐ DECLINE TO SPECIFY

LEGAL FIRST NAME/MI/LAST NAME:

PREFERRED NAME: | DOB:

EMAIL: | PHONE:

ADDRESS:

CITY: | STATE: | ZIP CODE: | PRIMARY LANGUAGE:

INSURANCE/MEDICAL EXPENSE SHARING MINISTRY:

☐ SAMARITAN MINISTRIES MEMBER ☐ OTHER MEDICAL EXPENSE SHARING MINISTRY ☐ INSURANCE COMPANY

EMPLOYER OF THE INSURED:

NAME OF MINISTRY/INSURANCE: | NAME:

SUBSCRIBER NUMBER: | PHONE NUMBER:

GROUP NUMBER: | FAX NUMBER:

SPOUSE INFORMATION (IF JOINING THE MEMBERSHIP):

LEGAL FIRST NAME/MI/LAST NAME:

PREFERRED NAME: | DOB:

EMAIL: | PHONE:

RACE: ☐ WHITE ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ OTHER ☐ DECLINE TO SPECIFY | PRIMARY LANGUAGE:

CHILDREN INFORMATION (IF JOINING THE MEMBERSHIP):

NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F
NAME:	DOB:	M F

COLLEGE INFORMATION (IF JOINING AS A COLLEGE STUDENT) :

COLLEGE NAME:

GRADUATION DATE:

EMERGENCY CONTACT

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):

PHONE: | RELATIONSHIP:

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):

PHONE: | RELATIONSHIP:

HOW DID YOU HEAR ABOUT US?

☐ SAMARITAN MINISTRIES ☐ TV ☐ RADIO ☐ BILLBOARD ☐ SOCIAL MEDIA ☐ ONLINE SEARCH ☐ WORD OF MOUTH

☐ CURRENT CHC MEMBER (NAME): ☐ OTHER

PAYMENT INFORMATION:

CHECKING/SAVINGS ACCOUNT:	CREDIT/ HSA CARD:	
NAME ON ACCT:	CARDHOLDER NAME:	
BANK NAME:	CARD #:	
ROUTING #:	EXP DATE:	
ACCT #	CVV:	ZIP CODE:

☐ TURN ON AUTOPAY INITIALS:

PREFERRED PAYMENT: ☐ BANK ACCOUNT ☐ CREDIT/HSA CARD ☐ CHECK ☐ CASH

I AFFIRM THAT THE INFORMATION PROVIDED ON THIS FORM IS CORRECT.

SIGNATURE OF APPLICANT: DATE:

SIGNATURE OF SPOUSE (ONLY FOR JOINT MEMBERSHIP): DATE:

☐ I AUTHORIZE CHRISTIAN HEALTHCARE CENTERS TO SEND EMAIL OR TEXT NOTIFICATIONS, WHICH MAY INCLUDE UNENCRYPTED PROTECTED HEALTH INFORMATION.

PLEASE MAKE ALL CHECKS PAYABLE TO:
CHRISTIAN HEALTHCARE CENTERS - 3322 BELTLINE CT. NE, GRAND RAPIDS, MI 49525
PHONE: 616-226-2669 | FAX: 616-920-6537 | EMAIL: INFO@CHCENTERS.ORG