Summit Senior Wellness Application for Membership

Member #1

Last Name:		M.I.:	Are you over the age of 50?
First Name:			
Phone Number with Area Code:		Date of Birth	Are there any healthcare topics you would like to know more about?
Mailing Address:			1
		Apt.	2
			3
City:	State:	Zip:	Email Address:

I authorize □ do not authorize □ that a Summit Senior Wellness representative may be notified of my admittance to participating hospitals and may contact me while in the hospital to ensure my needs are being met.

Signature: Date:

Member #2

Last Name:		M.I.:	Are you over the age of 50?
First Name:			
Phone Number with Area Code:		Date of Birth	Are there any healthcare topics you would like to know more about?
Mailing Address:			1
		Apt.	2
			3
City:	State:	Zip:	Email Address:

I authorize □ do not authorize □ that a Summit Senior Wellness representative may be notified of my admittance to participating hospitals and may contact me while in the hospital to ensure my needs are being met.

Signature: Date:

How did you learn about Summit Senior Wellness program?	

Member #1 last 4 digits of SSN: Confidential	
Member #2 last 4 digits of SSN: Confidential	

Pay by Check Only

□ One - One Year Membership $25.00 per member

□ One - Two Year Membership $40.00 (Save 20%)

□ Two - One Year Memberships $40.00

□ Two - Two Year Memberships $60.00 (Save 20%)