CAS Premier Health, LLC Membership Information

(Please complete a form for *each* member and PRINT all information)
ALL INFORMATION IS CONFIDENTIAL

Member's Full Legal Name (first, middle, last):

If already a member, if known, CAS Member Number: _____

_____ _____ _____
First Middle Last

Mailing Address:

_____
_____
_____

Physical Address (if different than mailing):

_____
_____
_____

Date of Birth (month/day/year): _____

Telephone Numbers (please star (*) preferred number):

Home:
_____
Work:
_____
Cell:
_____

Email Address (please star (*) preferred email address):

Home:
_____
Work:
_____
Other:
_____

Sex: M F **Marital Status** (please circle): Single Married Widowed Divorced Separated Partnered
Spouse's/Partner's Name: _____
Children's names and their dates of birth, if both adults in the family are members and children younger than 26 years:
_____

Payment Options (please mark which options you want):

□ Annual Membership Fee for 2020: **$**_____ **x 1** (due on January 1, 2020)
□ Monthly Membership Fees of **$**_____ **per month x 12** (charged around the beginning of the month).
□ Enclosed is my check/money order for $_____ OR
□ Please bill my credit card for $_____ once twelve times (please circle)

Credit Card Type (circle): AMEX MasterCard Visa Discover Exp. Date: _____

Card Number: _____ Security Code: _____

Name as it appears on card: _____ Zip Code of **billing address**: _____

I agree to have the amount(s) above charged to my credit card.

Signature: _____Date:_____