

Member Enrollment

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| MEMBER INFORMATION | | | | | | | | | | | | |
| Last Name: | | | | | | First: | | | | | | Middle: |
| Birth Date:  MM /DD/YYYY | | | | /    / | | | | | | Gender:  Male  Female | | |
| Home Address: | | | | | | | | | | | | |
| City:      State:      Zip: | | | | | | | | | | | | |
| Phone: (     )     −       Home  Cell | | | | | | | Phone: (     )     −       Home  Cell | | | | | |
| Email address: | | | | | | | | | | | | |
| Agreements | | | | | | | | | | | | |
| I have received a copy of the Retainer Medical Agreement/Direct Primary Care Agreement | | | | | | | | | | | | |
| Enroll Spouse/Dependent | | | | | | | | | | | | |
| Last Name: | | | | | First: | | | | | | Middle: | |
| Birth Date:  MM/DD/YYYY | | | /    / | | | | | Gender:  Male  Female | | | | |
| Phone: (     )     −       Home  Cell | | | | | | | | | Phone: (     )     −       Home  Cell | | | |
| Email address: | | | | | | | | | | | | |
| Enroll Additional Members in Household | | | | | | | | | | | | |
| **Dependent** | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | | | | | | | | | | | |
| **Dependent** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | | | | | | | | | | | | |
| **Dependent** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | | | | | | | | | | | | |

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| **Dependent** | |  |  |  |  |  | | --- | --- | --- | --- | --- | | Last Name: | | First: | | Middle: | | Birth Date:  MM/DD/YYYY | /    / | | Gender:  Male  Female | | | Alternate phone (if different than above: (     )     −       Home  Cell | | | | | | Email address: | | | | | |

**Membership Billing Information**

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| Billing Information |

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| Payment Schedule: | Monthly  Quarterly  Annual | | | **Enrollment fee of $85.00 per houshold** *(one-time fee with no lapse in membership, non refundable.)* |
| **Monthly Pricing:** | 1  *or* 2  Individual age 27 - 65 $69.00  1  *or* 2  Individual age 66 + $79.00  Independent youth $50.00  *(age 18 - 25, individual membership)* | | | 1 Adult, 1 child *(under age 26)* $84.00  Family 2 Adults, $158.00  *(up to 2 child thru age 25)*         Additional child $15.00 each  *(enter number)* |
| Desired Payment Date: | | 1st  5th | **Payment Method (choose one**)  Credit or Debit Card  Bank Account | |

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| Card type:  CC **or**  HAS/FSA  *(all cards accepted)* | |  | Bank Account Information | |
| Cardholder’s name: | |  | Account holders name: | |
| Card number: | |  | Bank name: | |
| Expiration Date: MM/YYYY | / |  | Account number: | |
| Security Code: | |  | Routing number: | |
| Authorization Sttement: I authorize Nicc’s Direct Primary Care, to charge my credit card, debit card, HSA/FSA card or bank account for an $85.00 one-time enrollment fee and on a recurring basis for my Retainer Medical Agreement/ Direct Primary Care Membership per the above selected frequency until I have cancelled my membership in writing with 30 days notice. If my credit card company or bank delince charges my membership is cancelled immedicately until I make another payment and may be subject to a re-enrollment fee. I also agree to pay a $25.00 NSF for any returned payment.  I understand that insurance will not be billed for services covered under my membership. | | http://kwc.edu/_uploads/sites/2/Check-Example.gif | | |
| Authorization Signature: | | | | Date:    /    / |

Email completed form: [admin@niccdpc.com](mailto:admin@niccdpc.com) Or mail: 4509 S. 6th Street, Suite 301 / Klamath Falls OR 97603