

FOR OFFICE USE ONLY

ACCT. #

DATE RECEIVED

# Immergrün, Inc.

## Medical Discount Card Application

New Individual Registration

New Family Registration

Update to Registration

(Type of update: moved death birth marriage dependant turned 21 other)

**PLEASE PRINT CLEARLY AND USE BLUE OR BLACK INK.**

### Instructions:

#### REGISTRATION:

Applications will be given to families by their churches.

Applications that are not fully completed will be returned for completion and will delay the registration process.

Completed registration should be returned to the designated church representative who will forward them to Immergrün.

After processing, identification cards will be sent to each family by Immergrün.

This card will cover all members included on the registration form.

Expiration of these cards will be determined by each church individually. This information will be included on the card.

#### UPDATING INFORMATION:

It is the responsibility of the head of household to notify Immergrün as to any changes of information.

Updates can be made using application forms.

Please select "Update to Registration" and type of update.

Forms can be obtained from the church or by calling 1-800-333-3561.

Completed update forms can be sent to:

**Immergrün, Inc.**

**4334 W. Central Ave., Ste 205**

**Toledo, OH 436115**

#### PRIVACY:

*The information Immergrün collects on its' patients is used only for diagnosis, treatment and billing purposes and will not be shared with others. No medical information is necessary for registration. No family can be turned down due to existing medical conditions.*

### A. HEAD OF HOUSEHOLD

LAST	FIRST	MI	DATE OF BIRTH	SEX	TAX ID # OR SOCIAL SECURITY #
				_M _F	- -
ADDRESS		CITY	ST	ZIP	
HOME PHONE # OR VOICEMAIL #		MARITAL STATUS	SPOUSE'S NAME		
EMERGENCY CONTACT		RELATIONSHIP TO PATIENT	CONTACT NUMBER		

SIGNATURE OF APPLICANT

I verify all of the information contained on this application is accurate to the best of my ability:

----- SIGNATURE ----- DATE

### B. PERSON OR GROUP RESPONSIBLE FOR PAYMENT - F OTHER THAN ABOVE

LAST	FIRST	MI	DATE OF BIRTH	SEX	TAX ID # OR SOCIAL SECURITY #
				_M _F	- -
ADDRESS		CITY	ST	ZIP	
HOME PHONE # OR VOICEMAIL #		MARITAL STATUS	SPOUSE'S NAME		
EMERGENCY CONTACT		RELATIONSHIP TO PATIENT	CONTACT NUMBER		

**Please print clearly with blue or black ink. Application is continued on the back.**

