ENROLLMENT FORM

PROTECTING YOUR FAMILY IS SIMPLE: Follow the instructions at the bottom of this page.

SERVICE SELECTION

(Select only one)

Minors Matter
CHILDREN UNDER 18
◯ **1 year** ◯ **5 years**

REFERRAL SOURCE *(Optional: Name of firm and/or professional that referred you to DocuBank)*

Firm/Provider Name: _____

MEMBER INFORMATION *(The name that will appear on the card. For Minors Matter, this is the child's info)*

Name: _____ **DOB:** *(MM/DD/YY)* ____ / ____ / ____

CONTACT INFO *(For Minors Matter, please provide address of member's parent/guardian)*

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

ALLERGIES: ◯ **Penicillin** ◯ **Sulfa** ◯ **Latex** ◯ **Peanuts** ◯ _____ ◯ _____

PERMANENT MEDICAL CONDITIONS *(Do not list medications)*

◯ **Diabetes** ◯ _____ ◯ _____ ◯ _____

Card Note *(45 char. max)* _____

EMERGENCY CONTACTS *(optional) If information is not available now, you can update it when you receive your card.*

1ST CONTACT
Name: _____ **Relationship:** _____
Home #: _____ **Work #:** _____
Cell #: _____ **Email:** _____

DOCTOR *(Primary Care)*
Name: _____
Phone #: _____ **Fax #:** _____
1ST CONTACT Note: _____

2ND CONTACT
Name: _____ **Relationship:** _____
Home #: _____ **Work #:** _____
Cell #: _____ **Email:** _____

3RD CONTACT
Name: _____ **Relationship:** _____
Home #: _____ **Work #:** _____
Cell #: _____ **Email:** _____

ADDITIONAL DOCUMENTS STORED *(Notation will appear on member's card)*

◯ **Medication List** ◯ **Health Insurance Information**

MEMBER STATEMENT: I have chosen to enroll my minor child or ward in DocuBank to help make their emergency information available promptly. To ensure prompt access, I authorize that my child or ward's, document(s), emergency contact and health information stored with DocuBank be accessible to anyone who provides the member number and PIN on the DocuBank member card. All documents have been completed of my own free will and I will notify DocuBank promptly of changes in any of the stored information, and also of the revocation or replacement of any document(s). I understand that: DocuBank is not responsible for the validity or accuracy of any information stored by DocuBank, including the health information that also appears on the member card; by accepting a card I have verified and confirmed the accuracy of all information on the card before carrying or distributing it; I am granting DocuBank permission to alert the contacts as indicated on this form; if I provide an email or cell phone for the emergency contact(s), I am granting DocuBank permission to contact these persons and provide them with member information. I understand that my DocuBank membership includes the optional use of the DocuBank SAFE, which provides online access to my personal documents. I understand that DocuBank does not provide legal advice; and that I may cancel this service in writing at any time by written request to DocuBank.

SIGNATURE: _____ **DATE:** _____
(parent/legal guardian)

TO ENROLL: Send this completed form, your payment and the relevant emergency documents *(e.g. Guardianship Forms, Temporary Health Care Power of Attorney, and more)*. You can also include an additional Emergency Information Form and Medication List, which are available at **docubank.com/forms**.

MAIL TO:
DocuBank
P.O. Box 629
Springfield PA 19064

EMAIL TO:
joindocubank@docubank.com

FAX TO:
610-667-1483

QUESTIONS?
Call 1-866-829-0993 or
visit DOCUBANK.COM