WELL CARE MEMBERSHIP APPLICATION

Simply complete the enrollment form below and **Return To: WEF Well Care Network Coordinator**

Enroll only family members for whom membership is desired. You need not enroll all family members.

If paying annually via credit/debit card, you may **fax this application to (256) 237-6007**.

LAST NAME FIRST NAME MIDDLE INITIAL

____

ADDRESS CITY STATE ZIP

____

MONTH TO BEGIN PLAN (STARTS ON 1ST) ______________________________

BIRTHDATE (MM/DD/YY) ___________________________ SEX ☐ M ☐ F

WORK PHONE ____________________HOME PHONE_______________________ EMAIL ADDRESS ____

MARITAL STATUS

☐SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SPOUSE –

LAST NAME FIRST NAME MIDDLE INITIAL

____

BIRTHDATE (MM/DD/YY) ___________________________ SEX ☐ M ☐ F

DEPENDENT– LAST NAME FIRST NAME MIDDLE INITIAL

____

BIRTHDATE (MM/DD/YY) _________________________ SEX ☐ M ☐ F

FULL –TIME STUDENT ☐Y ☐N

DEPENDENT– LAST NAME FIRST NAME MIDDLE INITIAL

____

BIRTHDATE (MM/DD/YY) _________________________ SEX ☐ M ☐ F

FULL –TIME STUDENT ☐Y ☐N

DEPENDENT– LAST NAME FIRST NAME MIDDLE INITIAL

____

BIRTHDATE (MM/DD/YY) _________________________ SEX ☐ M ☐ F

FULL –TIME STUDENT ☐Y ☐N

DEPENDENT– LAST NAME FIRST NAME MIDDLE INITIAL

____

BIRTHDATE (MM/DD/YY) _________________________ SEX ☐ M ☐ F

FULL –TIME STUDENT ☐Y ☐N

Please charge my checking account monthly. **I have enclosed a check for $96 made payable to Wellness Education Foundation, plus a voided check from the account to be debited annually/monthly.**

Failure to include may delay effective date.

Bank Name:____________________________City:________________- Account #: ________________________

☐ Draft Authorization/Member Agreement: Unless I have elected Annual Payment ($96.00) by check or credit card, I hereby authorize WADE & ASSOCIATES to charge my account monthly the one time application fee of $55.00 and the monthly membership fee ($7.00/mo), to be credited to my account with the Wellness Education Foundation. This authorization is to remain in full force and effect until I notify WADE & ASSOCIATES in writing of its termination. (My bank is authorized to make corrections if necessary). I have read and understand the terms of this authorization. I agree to maintain membership for a period of one year and to authorize monthly bank drafts during that year. Less than one year membership may result in being billed by the doctors at their usual and customary rate, minus membership fees paid. All membership fees are non refundable.

Authorized Signature: ____ Date: _______ / _______ / _______

Subscribers Signature: ____ Date: _______ / _______ / _______

Referred By____ Date: _______ / _______ / _______