

ENROLLMENT FORM

Parent's Name (First/M.I./Last): _____

Address (Street/City/State/Zip): _____

Phone (Area code/No.): **Home** (_____) _____ **Business** (_____) _____ **Cell** (_____) _____

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Current Health Insurance Coverage:

Primary Insurance: _____

Policy Number: _____

Primary Policy Holder's Social Security #: _____

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Child's Name

Date of Birth

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Plan Participants:

First Child	\$2500
Second Child	\$1500
Third Child	\$1000
Fourth Child and Any Additional Children	FREE

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Method of Payment: Paid annually by:

___ Check/Money Order. Make check payable to: Pediatric Platinum Care, Inc.

___ Credit Card (Master Card/Visa). Credit Card Account No. _____

Expiration Date (Month/Year) _____

Total Payment: _____

Signature: _____