CIG
CRUZ INSURANCE GROUP

QUE LO INESPERADO... NO TE QUITE LA PAZ..!®

HEALTH APPLICATION

MEMBER ID: 12345   **FFM ID: FFM5678**

RESIDENT ADRESS: *Calle Principal*   **APT:** *5B*   **CITY:** *Medallo*   **COUNTRY:** *Venezuela*   **STATE:** *Medallo*   **ZIP CODE:** *1000*

MAILING ADRESS: *Calle Principal*   **APT:** *5B*   **CITY:** *Medallo*   **COUNTRY:** *Venezuela*   **STATE:** *Medallo*   **ZIP CODE:** *1000*

PHONE: *555-1234-555*   **EMAIL:** *ejemplo@gmail.com*

CLIENTE
M ● F ○   COBERTURA Si ○ No ○   CITIZEN ○ RESIDENT ● EMPLOYEE CARD ○ OTHERS ○

Name: Juana   M-Name: Arcos   Last Name: Pérez   DOB: 01/01/1990   Age: 31

Place Of Birth: Ciudad De México   Categoría: Platino   Civil Status : Casado   Driver License: 12345678

Peso: 75 Kg   Talla: 1.80 M   SSN: 123-45-6789   A#: A1234567   Card: 1234 5678 9012 3456

SPOUSE
M ○ F ○   COBERTURA Si ● No ○   CITIZEN ○ RESIDENT ○ EMPLOYEE CARD ○ OTHERS ○

Name: María   M-Name: Elena   Last Name: García   DOB: 02/02/1992   Age: 29

Peso: 65 Kg   Talla: 1.70   SSN: 987-65-4321   A: A7654321   Card: 5678 9012 3456 7890

DEP.1
M ○ F ○   COBERTURA Si ○ No ○   CITIZEN ○ RESIDENT ○ EMPLOYEE CARD ○ OTHERS ○

Name: M-Name: Last Name: DOB: Age:

Peso: Talla: SSN: A: Card:

DEP.2
M ○ F ○   COBERTURA Si ○ No ○   CITIZEN ○ RESIDENT ○ EMPLOYEE CARD ○ OTHERS ○

Name: M-Name: Last Name: DOB: Age:

Peso: Talla: SSN: A: Card:

DEP.3
M ○ F ○   COBERTURA Si ○ No ○   CITIZEN ○ RESIDENT ○ EMPLOYEE CARD ○ OTHERS ○

Name: M-Name: Last Name: DOB: Age:

Peso: Talla: SSN: A: Card:

DEP.4
M ● F ○   COBERTURA Si ○ No ○   CITIZEN ○ RESIDENT ● EMPLOYEE CARD ○ OTHERS ○

Name: M-Name: Last Name: DOB: Age:

Peso: Talla: SSN: A: Card:

Income:
Empleador: Work Type:
Telef. Empleador:

Account Holder:
Bank: Routing #:   Account #:
Card: Exp: CVC:

Company: Efective Day: Plan Type: Plan: Monthly Premium:

PCP: _____
Specialis Doctor: _____
Emergency Room: _____
Medicine: _____
Deductible: _____
Out Pocket: _____

Firmo autorizando a mi Agente a procesar mi solicitud y comprendo que debo permanecer un período mínimo de un año con el Seguro suscrito. I sign authorizing my Agent to process my application and I understand that I must stay a minimum period of one year with the Insurance subscrited.

Fecha/Date: Firma/Signed: Inicial/Initial:

NOTA: Documentos posiblemente requeridos, ID, Estatus migratorio, Ingresos (Ejemplo: W2, Income Tax, Estados de cuenta, pay stubs).
NOTE: Documents possibbly required, ID, Migratory Status, Income (Example: W2, 1099, Income Tax, Statezments, pay stubs).