SimpleCare®
The Common-Sense Health Care Solution

Patient Renewal

PLEASE PRINT SO WE CAN READ YOUR INFORMATION ACCURATELY

Name: _____ _____ _____
Last First MI

Membership Number: _____ **Date Of Birth:** ____/____/____

Sponsor/Clinic Name /Provider: _____

Additional Family Members up to Six – $5 Each additional member : Include First Name, Last Name, DOB

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

6. _____ _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____- _____ **Alt #:** _____- _____

Email: (Required if available) _____

❑ **INDIVIDUAL $29/ 1 year** ❑ **FAMILY $39/ 1 year**

Amount: $ _____ **Make Check/Money Order To: AAPP/SimpleCare**

Credit Card: **Name on Card:** _____

❑ Visa ❑ Master Card **Card #:** _____

❑ Disc. ❑ Amer. Express. **Expiration Date:** _____ /_____

Authorized Signature _____

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