



SimpleCare®

The common-sense health care solution!

*Please fill out your information as you would like it to be listed in the on-line SimpleCare® directory.
If you do not want to be included in the directory, please write, "Do not list on web site" at the top of this application.*

Insurance Provider Enrollment Form

First Name: _____ **Middle:** _____ **Last:** _____

Professional Qualifications: _____ **Other Suffix:** _____

Phone: _____ **Toll-Free:** _____ **Fax:** _____

Tax ID #: _____ **Insurance Specialty:** _____

Email (optional): _____ **Website:** _____

Office Contact Person _____ **Phone** _____

Name of Agency/Brokerage _____

Mailing Address:

Agency Address (if different):

Line 1 _____ Line 1 _____

Line 2 _____ Line 2 _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

**If you have more than one location, note your primary location here and attach a separate sheet with the additional information.*

Take the SimpleCare® Pledge:

"I will give SimpleCare® members my best professional guidance."

Signature _____ **Date:** _____

Method of Payment for SimpleCare® Membership (10% discount for NAIFA Members: ID # _____)

Check/Money Order – Make checks out to AAPP/SimpleCare® (\$125 per provider) (Renewals \$50 per provider)
Amount enclosed: \$ _____

Credit Card (\$125 per provider – 1st year only) (Renewals \$50 per provider per year after the first year)

Please charge my credit card \$ _____

[] Visa

[] Mastercard Name on card: _____

[] American Express Card #: _____ Expires: _____

[] Discover Authorized Signature: _____

Where did you hear about SimpleCare® ? _____

SimpleCare Associates: Please pre-print your ID# on the line above so we can easily track the members you enroll.

Please send completed enrollment form and payment to:

SimpleCare® Membership Center
4300 Talbot Rd South, Suite 314
Renton, WA 98055

Fax: 425-254-1111
Phone: 425-255-4166
Enroll online: www.simplecare.com
E-Mail: membership@simplecare.com