MAGNACARE GROUP
PRESCRIPTION CARD APPLICATION

First Name:______________________________ Last Name: _______________________
Address:______________________________ City: _______________________________
Zip Code: _________ State_________ Phone With Area Code:____________________
Social Security No:______________ Date of Birth ____________ (example 09/09/1952)

If applying for spouse coverage:

Spouse First Name:__________________ Social Security No: _________________
Date of Birth: _____________ (example 09/09/1952)

If applying for dependent coverage:

Dependent First Name:________________ Dependent Last Name:__________________
Social Security No:________________ Date of Birth:_____________ (example 09/09/1952)

Dependent First Name:________________ Dependent Last Name:__________________
Social Security No: _______________ Date of Birth:_____________ (example 09/09/1952)

Dependent First Name:________________ Dependent Last Name:__________________
Social Security No:______________ Date of Birth: _____________ (example 09/09/1952)

Submit a check for payment as follows:

Premium due with application:
I person Annual Premium-$25.00
2 person Annual Premium-$50.00
Child Dependents with parents- $15.00 each

Please mail your application and
Check made payable to:

MagnaCare Group, Inc.
6140 28th Street S.E., Suite 200
Grand Rapids, MI 49546

OR

Click here to fill out Check information
Then Fax Application and Check information to
616-949-8595