TBT Co-Op Clinics
PO Box 62230
Houston, TX 77205-2230
Fax: 866-234-8707

SENIOR PATIENT ASSOCIATION MEMBERSHIP APPLICATION

Primary Applicant's Last Name	First	M	Age	Birth Date (MM/DD/YYYY)
Residence Address	City	State		Zip
Mailing or Billing Address (if Different than Residence)	City	State		Zip
Social Security Number	Home Phone	Work Phone		Cell Phone
E-mail address:				

MEMBERS OF HOUSEHOLD AND BENEFIT SELECTION

Benefit Codes

Last Name	First Name	M	Relationship To Primary	Sex	DOB (MM/DD/YYYY)	Tobacco (Y/N)	COOP	CL	CD	GH	GA	GCI	Primary Care Provider For CoOp Benefits
Primary Member Name Shown Above			Self										

TERMS AND AGREEMENTS:

Agreement for automatic bank draft (Attach a voided check to this application)

I (we) authorize the financial institution named below to honor and pay these monthly charges. This authority is to remail in effect until revoked by me (us) in writing, and until you actually receive such notice, I (we) agree that you shall be fully procted in honoring any such check/draft. I (we) understand that in order to cancel these automatic deductions, I (we) must provide written notice to the Senior Patient Association no less than 15 days befor the next scheduled automatic deduction in writting.

Account Holder Signature ____________________ Date __________

Agreed Initial Charges

Billing Method: ☐ CHECK ☐ CREDIT ☐ DEBIT	Amount:	Check #:

Agreed Monthly Charges

Billing Method: ☐ DRAFT ☐ CREDIT ☐ DEBIT ☐ ANNUAL	Amount:	Billing Day: ☐ 1st ☐ 5th ☐ 15th
Account Name (Print Clearly)		
Bank Name	Bank Routing Number	
Checking Account Number		

Name on Credit/Debit Card:	Credit/Debit Card Type: ☐VISA ☐MASTERCARD ☐AMEX ☐DISCOVER ☐OTHER	
Credit/Debit Card Number:	Credit/Debit Card Expiration Date: ______/______	CVV CODE#

APPLICANT'S SIGNATURE ______________________________ Date __________

CL=Clinic PCP Services CD= Diagnostic-Radiology
GH=Group Health GA= Group Accident GCI=Group Critical Illness