

# Free CAP Enrollment Form

HealthCare Advocates, Inc.

Fax: 215-735-7737

Email: [info@healthcareadvocates.com](mailto:info@healthcareadvocates.com)

Please fill out the following information and return to **Stacy Goebel**, your Life Support Medical representative. HealthCare Advocates, Inc. will forward your Membership Package to you. Your free membership (a \$300 per year value) covers all family members living at the address you provide below. Your initial membership period is two years. Your free membership agreement will automatically renew, every two years. (If free membership option is ever discontinued, you will be notified and may choose to opt out at that time.)

## Primary Member Information

First Name	
Last Name	
Street Address	
City	
State	
Zip/Postal Code	
Telephone	
Email Address	
Date of Birth	

## Dependant Information

First Name	Last Name	Date of Birth	Email Address

I understand that HealthCare Advocates, Inc. will send my Membership Package via email, that I am under no obligation to complete the enrollment process and that I can cancel my CAP membership at any time.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

Agent	39821	Organization	31283	General Agent	43289	Status	1 2
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