

Senior Advocate Application Form

Please fill out this form as completely as possible.

If you have any questions, please call 1.800.3.ADVOCATE (1.800.323.8622).

First Name _____

Last Name _____

Address _____

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

Daytime Phone

(_____) _____

E-mail Address _____

Location

Please select the Advocate hospital at which you'd like to participate in Senior Programs:

- | | |
|---------------------------------|---------------------------------------|
| _____ Bethany Hospital | _____ Christ Medical Center |
| _____ Good Samaritan Hospital | _____ Good Shepherd Hospital |
| _____ Lutheran General Hospital | _____ Illinois Masonic Medical Center |
| _____ South Suburban Hospital | _____ Trinity Hospital |

Marital Status

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Married | <input type="checkbox"/> Single |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |

Gender

- | | |
|-------------------------------|---------------------------------|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female |
|-------------------------------|---------------------------------|

Date of Birth

Month / Day / Year

Insurance

(check all that apply)

Medicare A

Medicare B

Your Medicare Number _____

Medicare HMO

Name of Plan _____

Medicare Supplemental Insurance Plan

Name of Plan _____

Policy Number _____

Medicaid

Employer/Other Insurance

Name of Plan _____

Policy Number _____

Medical Information

Do you have a physician?

Yes No

Physician's Name

Physician's Phone

(_____) _____

By checking this box, I state my understanding that the Senior Advocate program offered by Advocate Health Care is not an insurance policy.