AGING. BETTER.

Membership Application **Date**___/___/_____

Member Fees: ☐$360 Individual ☐$600 Household

(contact our office if you wish to to arrange automatic monthly payments)

*If you and your partner/spouse live in the same household, then the household membership applies.

Primary Member: _____

Birth date: _____ Gender: ☐F ☐ M

Address: _____ City:_____ Zip code:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Spouse/Partner (if applicable): _____

Birth date: _____ Gender: ☐ F ☐ M

Home Phone: _____ Cell Phone: _____

Email: _____

Other Contact Information (* items are required)

*Emergency Contact 1: _____ *Relationship to you:_____

*Email: _____ *Phone:_____

Emergency Contact 2: _____ Relationship to you: _____

Email: _____ Phone: _____

*Primary Care Physician: _____ Phone: _____

*Hospital Affiliation: ☐Alta Bates/Summit ☐ John Muir Health ☐ Kaiser ☐ Other:_____

*Current insurance provider (Medicare, Health Net, etc):_____

Additional Information How did you hear about Lamorinda Village?

☐Friends ☐Living Room Chat ☐ Flyer/Newsletter ☐Community event

What interests you in becoming a member of Lamorinda Village?

_____

Mail your completed application and payment to:

P.O. Box 57, Lafayette, CA 94549 **Phone: (925) 283-3500**