

**ABC-Rx SELECT
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:
1 person Monthly Premium-\$15.00
2 person Monthly Premium-\$25.00
Child Dependents with parent(s) - Monthly Premium - \$29.00

**Please mail your application and
Check made payable to:**

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