MAXORplus®
PHARMACY BENEFIT MANAGEMENT SERVICES

MAXORPLUS Membership Eligibility Form

Member Information

Plan Name: _____

Member Name: _____ (First) _____ (M.I.) _____ (Last)

New Member ☐ Delete Member ☐ (Check One)

Social Sec. #:
Person Code: 01
Group #:
Effective Date:
Birthdate:

Sex (M) ☐ (F) ☐

Address: _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

Dependents' Information

SPOUSE
Name:
Person Code #: 02
Effective Date:
Birthdate:
Add or Delete Dependent ☐
Sex (M) ☐ (F) ☐

Name:
Person Code #: 03
Effective Date:
Birthdate:
Add or Delete Dependent ☐
Sex (M) ☐ (F) ☐

Name:
Person Code #: 04
Effective Date:
Birthdate:
Add or Delete Dependent ☐
Sex (M) ☐ (F) ☐

Name:
Person Code #: 05
Effective Date:
Birthdate:
Add or Delete Dependent ☐
Sex (M) ☐ (F) ☐

Name:
Person Code #: 06
Effective Date:
Birthdate:
Add or Delete Dependent ☐
Sex (M) ☐ (F) ☐

Please fax to MAXORPLUS at 806-324-5552

Date and Time Faxed or Emailed: _____

Signature