MEMBER ENROLLMENT AND CHANGE FORM

(Please Print Legibly)

Member Name:	
Member Date of Birth:	
Member ID Number:	
Member Phone Number (please include area code) :	

Covered Family Members:

First and Last Name	Date of Birth	Sex	Physician Name

Signature

PLEASE COMPLETE AND RETURN TO:

DuPage Medical Group
Attn: Dorothy Davis
P. O. Box 3358
Glen Ellyn, IL 60138
(630) 942-7998 - Customer Service
(630) 545-4010 - Fax