



Eritrean Cultural, Civic, & Community Center APPLICATION FORM

Today's Date:		Membership ID #		
MEMBER INFORMATION				
First name:		Last name:		Middle: [Initial]
Marital status:				
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?	Birth date:	Age:	Sex: <input type="radio"/> M <input type="radio"/> F
Address: [Address/ P.O Box, City, ST ZIP Code]				
Eritrean ID #:		Home phone no.:		Cell phone no.:
Email Address:		Which of these organizations do you belong to?		
		<input type="checkbox"/> PFDJ <input type="checkbox"/> PFDJ 2 <input type="checkbox"/> HIDRI <input type="checkbox"/> YPFDJ <input type="checkbox"/> NUEW <input type="checkbox"/> Not Applicable		
Which Membership Category are you applying for?				
<input type="checkbox"/> Family with Kids 18 & Under <input type="checkbox"/> Couple (no Kids) <input type="checkbox"/> Singles Ages 25 & up) <input type="checkbox"/> Youth (Ages 18-25)				
Other family members Information:				
1. Name: _____, Birth Date: _____, Age: _____				
2. Name: _____, Birth Date: _____, Age: _____				
3. Name: _____, Birth Date: _____, Age: _____				
4. Name: _____, Birth Date: _____, Age: _____				
5. Name: _____, Birth Date: _____, Age: _____				
IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to member:	Home phone no.:	Work phone no.:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Eritrean Cultural, Civic, & Community Center or insurance company to release any information required to process my claims.				
Applicant signature			Date	