

NAME		PLEASE PRINT CLEARLY	
First Name _____ Middle Initial _____ Last Name _____			
OPTIONAL: AUTHORIZED BUYER INFORMATION (must be at least 18 years of age).			
First Name _____ Middle Initial _____ Last Name _____			
PLEASE SIGN BELOW			
<p>Your application is for a Citi Health Card which links to two separate accounts: one account for purchases made at Citi Health providers ("the Citi Health Card account") and another account for purchases made at other merchants who accept MasterCard credit cards (the "Citi Health MasterCard account"). If you do not qualify for the Citi Health MasterCard account, you may receive a Citi Health Card account, and your card may only be used to make purchases at Citi Health providers.</p> <p>By signing below, I certify that I have read and agree to the Credit Card Disclosures, Terms and Conditions of Offer and Initial Disclosure Statement, all of which are attached. I also agree to be bound by the terms and conditions of the Citibank Card Agreement(s) that will be sent with my card if credit is granted and I agree to pay all charges incurred under such terms.</p>			
APPLICANT'S SIGNATURE		DATE	
Pre-Approved offer details: (if applicable)			
Pre-Approved Sequence Number _____	Pre-Approved Offer Date _____	\$ _____	Pre-Approved Credit Line
OFFICE USE ONLY: It is important this section is filled out completely and legibly.			
Web Application Processing		Provider Phone Application Processing Available for both providers and consumers at WWW.HEALTHCARD.CITICARDS.COM	
Provider Phone Application Processing		1-888-444-Citi (office use only-not for consumer use)	
Fax all completed applications after they have been processed. This is not necessary if the consumer has applied using the consumer web or the consumer phone application.		1-866-393-7006 and Mail to: Citi Health Card, C/O DataVision, 84 East School Street, Carlisle, IA 50047 (office use only-not for consumer use)	
<input type="checkbox"/> I have verified the applicant is at least 18 years of age. <input type="checkbox"/> I have verified the application is complete and signed. <input type="checkbox"/> I have verified two forms of I.D. (first I.D. must have a photo).			
\$ _____	Citi Health Card Merchant I.D. Number _____	Employee Name _____	Office Phone Number _____
Applicant 1st I.D. Type & Number: <input type="checkbox"/> Driver's License <input type="checkbox"/> State I.D. <input type="checkbox"/> Federal Government		Issuing State _____	Exp. Date _____
Approved Citi Health Card Account Number _____		\$ _____ Approved Credit Line	
Pending Number (if applicable) _____		Report Code (if applicable) _____	
Reference Number (if applicable). Ask for another form of payment.			
Citi Health Card Pad App DA	402CHMP-S	Version G	Revision# 0108

Provider Copy

INFORMATION ABOUT YOURSELF		PLEASE PRINT CLEARLY	
Street Address (No P.O. Boxes) _____ Apt. _____		City _____ State _____ Zip Code _____	
(Area Code) Home Phone _____	Social Security Number _____	Date of Birth _____	(Area Code) Business Phone _____
Homeowner? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gross ANNUAL Household Income* Must be \$10,000 or more to qualify	
*Alimony, Child Support or separate maintenance income need not be disclosed if you do not wish to have it considered as a basis for paying this obligation.			
OPTIONAL: AUTHORIZED BUYER INFORMATION (must be at least 18 years of age).			
Name _____		Social Security Number _____	
		Date of Birth _____	

Customer Copy

DATE # 0108