Citi® Health Card

citi

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

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.

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.

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)**

☐ I have verified the applicant is at least 18 years of age. ☐ I have verified the application is complete and signed. ☐ I have verified two forms of I.D. (first I.D. must have a photo.)

$ Estimated amount of total treatment cost and/or purchase. Citi Health Card Merchant I.D. Number Employee Name Office Phone Number

Applicant 1st I.D. Type & Number: ☐ Driver's License ☐ State I.D. ☐ Federal Government Issuing State Exp. Date Applicant 2nd I.D. Type

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? ☐ Yes ☐ 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

DATE # 0108

Customer Copy