

**COMPLETE ALL SECTIONS. If you have questions, call 1-866-352-5203.**

**Step 1**  
Participant Information

<b>How did you learn about the Citi Health Card?</b>			
Legal Business Name of Participant		DBA	
Health Care Specialty	<input type="checkbox"/> Dental (indicate specialty) <input type="checkbox"/> Orthodontia	<input type="checkbox"/> Vision Surgical <input type="checkbox"/> Vision Non-Surgical	<input type="checkbox"/> Hair Replacement <input type="checkbox"/> Hearing Professional <input type="checkbox"/> Veterinary
Primary Contact (OM, FC, TC)			# of Employees
Business Address			
City	State	Zip Code	Current Annual Bankcard Volume
Business Phone		Business Fax	Bankcard Processor
Business Web Site		Email*	Average Bankcard Ticket
Type of Ownership	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> Other
Federal Tax ID#			Percent of Ownership
Federal Tax ID#		Years in Business	

*If you have additional locations, please complete "Step 6" for each additional location.*

**Step 2**  
Principal's Information  
Must indicate agreement to terms by signing below

Name		Social Security Number	
Home Address			
City		State	Zip Code
Home Phone		Have any of the owners or officers ever filed for bankruptcy? If yes, please provide the name and date:	

*Please provide current license information; if applicable, also indicate any previous states where you've held your license.*

**Step 3**  
License Information

Name	License #	Specialty
Name	License #	Specialty

*If you have more than 2 providers, please attach a separate list with the above information.*

**Step 4**  
Attach a Voided Check

**Please designate the bank account ("Settlement Account") you would like to use for settlement through the automated clearinghouse network of Citi Health Card transactions, in accordance with the attached Citi Health Card Participating Provider Agreement.**

**A VOIDED CHECK IS REQUIRED.**

**Please fax a copy of the voided check along with the application.**

*Please provide a copy of your professional and/or business licenses along with the voided check.*

**Step 5**  
Signature

**SIGNATURE OF PRINCIPAL OWNER IS REQUIRED FOR PROCESSING.**

The undersigned Participant applies to accept the Citi Health Card issued by Citibank (South Dakota), N.A. ("Citibank"), at Participant's place of business. The person signing below ("Authorized Signer") affirms that he/she is an officer, general partner or owner of Participant, and has express authority to submit this application on Participant's behalf and to bind Participant to the Citi Health Card Participating Provider Agreement (SCHEIN-0408) (the "Agreement"). The Authorized Signer agrees individually and on behalf of Participant that (i) Citibank (South Dakota), N.A. and any person or entity acting on its behalf is authorized at any time to make whatever inquiries about Participant and the Authorized Signer that Citibank may deem appropriate to any person or entity, including, but not limited to any consumer reporting agency; and (ii) any such person or entity is authorized to furnish to the Bank any information that such person or entity may have or obtain concerning Participant or the Authorized Signer. The foregoing authorizations shall be effective upon submission of this application and shall remain in effect until Citibank rejects the application or, if Participant is approved, until all obligations of Participant under the Agreement have been satisfied in full. Participant represents and warrants to Citibank that all of the information in this application or otherwise provided in connection with this application is true, accurate and complete. Participant authorizes Citibank to initiate credits and debits as applicable for the payment of Citi Health Card transactions, fees and other charges to the Settlement Account listed above in accordance with the terms of the Agreement. Participant agrees to the terms and conditions contained in the Agreement and acknowledges receipt of a copy of the Agreement.

Signature of Authorized Principal (Owner or Officer)	Date
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**CONTINUED ON BACK**

**CITI HEALTH CARD USE ONLY**

MKTG Source Code #: \_\_\_\_\_ Merchant #: \_\_\_\_\_ GEID #: \_\_\_\_\_

Rep #: \_\_\_\_\_ Source #: \_\_\_\_\_

**Step 6**  
Additional Location(s)

Photocopy and complete for each additional location.

*If applicable for your practice, please photocopy and complete this section for EACH additional office location being enrolled.*

Company Name		DBA (if applicable)	
Site Address		City	
Site Contact Name		State	Zip Code
Phone Number	Fax Number	Email Address*	
Licensed Professional Name		License #	

**To enroll more than one additional location, photocopy this page and submit a completed "Step 6" for each additional location along with your completed application and voided check.**

\*Email may be used to communicate program information regarding the Citi Health Card Program.

**Step 7**  
Submit

**BEFORE SUBMITTING YOUR APPLICATION, PLEASE ENSURE THE FOLLOWING:**

- All fields of the application are complete
- If you are submitting one or more additional locations, "Step 6" was photocopied and filled out for each additional location
- A voided check has been included
- The principal owner of the business has signed the application

Then fax your application, and a copy of a voided check to **1-866-352-5204** and a Citi Health Card representative will be in contact with you soon.

**CITI HEALTH CARD USE ONLY**

Citi Merchant #: \_\_\_\_\_

Citi Merchant Headquarters #: \_\_\_\_\_