



HPA RX COPAY DRUG CARD MULTIPLE APPLICANTS ENROLLMENT AND LIST BILL FORM

List Bill To:	Tele:	Fax:	Email:
Address:	City:	Zip:	
Solicitor:	Tele:	Fax:	HPA #:
MGA:	HPA #:		

(Minimum 5 applicants for list bill.)
Indicate # applicant for this List bill: _____

PAYMENT BY: Check ___ Credit Card: ___ Type: MC ___, Visa ___, or Discover ___
 Name on Card: _____ Card #: _____ Exp. Date: _____
 Total Due: \$ _____ Authorized Signature: _____

	First Name	Last Name	Home Phone #	SS#	DOB	Sex	Email	Type*	Add Enroll. Fee	Cost
Applicant:									\$15.00	\$
Spouse:										
Child:										
Child:										
Child:										
Applicant:									\$15.00	\$
Spouse:										
Child:										
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Applicant:									\$15.00	\$
Spouse:										
Child:										
Child:										
Child:										
Applicant:									\$15.00	\$
Spouse:										
Child:										
Child:										
Child:										

All fields must be completed for each applicant. The Fulfillment and ID will be emailed.
 *Type: S - single; SS - single + spouse; SC - single + children; SF - single + family

MAIL LIST AND PAYMENT TO:

HPA, INC.
15438 N. FLORIDA AVE, #105
TAMPA, FL 33613
1-888-FAX-HPA1

FAX LIST - CREDIT CARD PAYMENT: