# MUSLIMCARE MEMBERSHIP REGISTRATION FORM

New Application ☐
Modification ☐
*(Include modifications only)*
Membership# ☐

Address: 270 Yorkland Blvd., North York, ON M2J 5C9, Ph: 647-616-2599, email: info@muslimcare.ca; Website:www.muslimcare.ca

## MEMBER

| NAME | GENDER | | DATE OF BIRTH |
|---|---|---|---|
| | Male | Female | MM/DD/YYYY |
| | ☐ | ☐ | |

## MEMBER ADDRESS & CONTACT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| APT/UNIT # | | STREET NO. & NAME | | | |
| CITY | | PROVINCE | | POSTAL CODE | |
| COUNTRY | | HOME PHONE# | | CELL PHONE # | |
| PRIMARY EMAIL | | SECONDARY EMAIL | | | |

## DEPENDENTS (Maximum 25 years old and must live at the same address)

| S.No | NAME | GENDER | | DATE OF BIRTH | RELATIONSHIP TO MEMBER |
|---|---|---|---|---|---|
| | | MALE | FEMALE | MM/DD/YYYY | |
| 1 | | ☐ | ☐ | | |
| 2 | | ☐ | ☐ | | |
| 3 | | ☐ | ☐ | | |
| 4 | | ☐ | ☐ | | |
| 5 | | ☐ | ☐ | | |
| 6 | | ☐ | ☐ | | |

## BENEFICIARY DESIGNATION

### PRIMARY BENEFICIARY'S ADDRESS & CONTACT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| NAME | | RELATIONSHIP TO THE APPLICANT | SPOUSE ☐ | OTHERS | |
| APT/UNIT # | | STREET NO. & NAME | | CITY | |
| PROVINCE | | POSTAL CODE | | HOME PHONE# | | CELL PHONE# | |
| PRIMARY EMAIL | | SECONDARY EMAIL | | | |

### SECONDARY BENEFICIARY'S ADDRESS & CONTACT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| NAME | | RELATIONSHIP TO THE APPLICANT | SPOUSE ☐ | OTHERS | |
| APT/UNIT # | | STREET NO. & NAME | | CITY | |
| PROVINCE | | POSTAL CODE | | HOME PHONE# | | CELL PHONE# | |
| PRIMARY EMAIL | | SECONDARY EMAIL | | | |

## PAYMENT INFORMATION

| | | | |
|---|---|---|---|
| BANK INSTITUTE NAME | | BRANCH TRANSIT NUMBER | |
| INSTITUTE NUMBER | | ACCOUNT NUMBER | |

## Membership and Authorization checklist

- ☐ I agree with the MuslimCare membership terms and conditions.
- ☐ I authorize MUSLIM CARE to withdraw MAXIMUM $20 for any DEATH occurs among Members' Family.
- ☐ I agree to pay MUSLIM CARE $150 non-refundable one-time membership fee through automatic online Withdrawal.
- ☐ I understand that I am not automatically an active member by completing this registration form. My registration will be activated and effective only after a confirmation notification and membership fee payment withdrawn from my bank account.
- ☐ I understand it is my responsibility as a member to inform MUSLIM CARE of any changes in the above information (Banking/Address/Phone#/Family situation)IMMEDIATELY.
- ☐ I understand it is the responsibility of the member for additional charges if payment results in NSF charges incurred by MUSLIM CARE.
- ☐ I agree to allow MUSLIM CARE to send emails related to the administration and marketing of this membership.
- ☐ I also understand that a sum of CAD 5,000.00 will be provided to my Beneficiary at the time of my or my dependeant's death to cover the funeral cost.
- ☐ I understand and agree that all the information provided on this form is true, accurate and binding, and dependents and beneficiaries **listed above ONLY will be considered eligible if their official ID's match with the information provided**, while disbursing CAN 5,000 in the event of Death.

| APPLICANT'S SIGNATURE | DATE: MM/DD/YYYY |
|---|---|
| | |