

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
	<input type="checkbox"/>	<input type="checkbox"/>	

MEMBER ADDRESS & CONTACT INFORMATION

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

DEPENDENTS: Spouse & your Children only (Must reside at the same address and should be below 25 years old)

S.No	NAME	GENDER		DATE OF BIRTH	RELATIONSHIP TO MEMBER
		MALE	FEMALE	MM/DD/YYYY	
1		<input type="checkbox"/>	<input type="checkbox"/>		
2		<input type="checkbox"/>	<input type="checkbox"/>		
3		<input type="checkbox"/>	<input type="checkbox"/>		
4		<input type="checkbox"/>	<input type="checkbox"/>		
5		<input type="checkbox"/>	<input type="checkbox"/>		
6		<input type="checkbox"/>	<input type="checkbox"/>		

BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY'S ADDRESS & CONTACT INFORMATION (Other than the Dependents Age 18+)

NAME	RELATIONSHIP TO THE APPLICANT	
HOME PHONE#	CELL PHONE#	
PRIMARY 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 Janaza Contribution* for any DEATH occurs among Members' Family.

I agree to pay MUSLIM CARE one-time non-refundable membership registration 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 My registration will be activated* and effective only after a confirmation notification and membership fee amount withdrawn from my bank account.

I understand it is my responsibility as a member to inform MUSLIM CARE of any changes in the information (Banking/Address/Phone#/Family situation/Designated Beneficiary) IMMEDIATELY.

I understand it is the responsibility of the member for additional charges if payment results in NSF charges incurred by MUSLIM CARE

I understand my membership shall be automatically SUSPENDED in view of 3 or more outstanding payment issues for Death/Janaza Contribution

I agree to allow MUSLIM CARE to send emails related to any updates and correspondences related to my membership.

I understand and agree that all the information provided on this form is true, accurate and binding, and dependents and beneficiary **listed above ONLY will be considered eligible if their official ID's match with the information provided**, to facilitate us in issuing the entitled cheque in the event of Death.

APPLICANT'S SIGNATURE	DATE: MM/DD/YYYY

*Please refer to Muslimcare Guidelines for the details and specifications (If the dependents are more than 6 numbers, use additional form or use the backside space)

Note: Make sure that a VOID CHEQUE / DIRECT WITHDRAWAL FORM is enclosed along with this application