GATEWAY HEMOPHILIA ASSOCIATION

4976 Eichelberger Street
St. Louis, MO 63109

Phone: (314) 482-5973 **Email:** info@gatewayhemophilia.org

GHA MEMBERSHIP FORM

Member(s) Name(s): _____

Address**:** _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Email address: _____

Date of Birth: _____ Bleeding Disorder _____

Name of Hematologist/HTC _____ Employer _____

What kind of insurance do you have? ___ Medicaid ___ Medicare ___ Marketplace ___ Tricare

___ Employer Plan ___ Individual Insurance Plan ___ Unknown

What is your preferred way to receive communication from us?

___ Text ___ Email ___ Phone call ___ Other If other, explain _____

☐ Would you like to receive GHA's Newsletter via email?

Please complete the following information for EVERY family member that is considered part of this membership. (Bleeding Disorder Yes = someone who has a confirmed diagnosis and has a treatment plan.)

Family Member 1 Name: _____ Date of Birth: _____
*This family member has a Bleeding Disorder: Yes or No If yes, name bleeding disorder _____

Family Member 2 Name: _____ Date of Birth: _____
*This family member has a Bleeding Disorder: Yes or No If yes, name bleeding disorder _____

Family Member 3 Name: _____ Date of Birth: _____
*This family member has a Bleeding Disorder: Yes or No If yes, name bleeding disorder _____

Family Member 4 Name: _____ Date of Birth: _____
*This family member has a Bleeding Disorder: Yes or No If yes, name bleeding disorder _____

Family Member 5 Name: _____ Date of Birth: _____
*This family member has a Bleeding Disorder: Yes or No If yes, name bleeding disorder _____

Family Member 6 Name: _____ Date of Birth: _____
*This family member has a Bleeding Disorder: Yes or No If yes, name bleeding disorder _____

Signature: _____ Date: _____