

<b>1 NAME OF APPLICANT</b>					
LAST NAME		FIRST NAME			INITIALS
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		DATE OF BIRTH	D:	M:	Y:
<b>2 NAME OF SPOUSE (marriage certificate is required)</b>					
LAST NAME		FIRST NAME			INITIALS
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		DATE OF BIRTH	D:	M:	Y:
<b>3 MARITAL STATUS</b>					
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other:		DATE OF MARRIAGE	D:	M:	Y:
<b>4 CONTACT INFORMATION</b>					
ADDRESS			CITY	PROV	P. CODE
APPLICANT EMAIL	CELL	HOME	WORK		
SPOUSE EMAIL	CELL	HOME	WORK		
CHURCH NAME			CHURCH LOCATION		
<b>5 DEPENDENT CHILDREN (under the age of 20 and not married)</b>					
LAST NAME	FIRST NAME	INITIAL	GENDER	BIRTHDATE	
			<input type="checkbox"/> M <input type="checkbox"/> F	D:	M: Y:
			<input type="checkbox"/> M <input type="checkbox"/> F	D:	M: Y:
			<input type="checkbox"/> M <input type="checkbox"/> F	D:	M: Y:
<b>6 DOCUMENTATION REQUIRED (for applicant and spouse)</b>					
<input type="checkbox"/> CISBF Payment Option Form <input type="checkbox"/> Birth Certificate <u>OR</u> Driver's License <input type="checkbox"/> Marriage Certificate					
<b>7 PRIVACY ACT ACKNOWLEDGEMENT (CISBF Bi-Annual Letter Listing Deceased Members)</b>					
<input type="checkbox"/> I agree to have my name published <input type="checkbox"/> I do <u>NOT</u> agree to have my name published					
<b>8 DECLARATION FOR MEMBERSHIP</b>					
I, the applicant, hereby certify that neither I nor any family listed is or has been under the care of a physician for a life-threatening condition within the last twenty-four months. The CISBF Board reserves the right to refuse payment of benefits if any know life-threatening condition is not disclosed.					
PHYSICIAN FULL NAME		CONTACT NUMBER		LOCATION	
I, the applicant, submit my application for membership in the <i>Christian Immigration Society Burial Fund</i> and agree to the Society's bylaws and amendments thereto. I agree to pay any associated entrance fee and the membership dues as required, and to provide any status change (marital status, children, address, phone, email, banking, etc.)					
<b>9 SIGNATURES</b> <span style="float: right;">* Applications require CISBF Board approval</span>					
APPLICANT (FULL NAME)		DATE		SIGNATURE (if electronic enter full name)	
CISBF BOARD APPROVAL (FULL NAME)		DATE		SIGNATURE	

***If you have family or friends that may be interested in joining CISBF please let us know and we will connect with them!***