Renewal Form

Primary Applicant (Please print clearly) Acclaim Card ID # ________________________

Name ____ ☐ Male ☐ Female

Address ____

City ________________________________ State ______________ Zip ______________________________

Phone (______) ____ Birthdate _____/_____/_____

Acclaim may also be used by relatives living in your household. Please list below.

1. Name ____

Relation ____ Birthdate _____/_____/_____

2. Name ____

Relation ____ Birthdate _____/_____/_____

3. Name ____

Relation ____ Birthdate _____/_____/_____

4. Name ____

Relation ____ Birthdate _____/_____/_____

Name of your Participating Chiropractic Physician (APCP) ____

Phone Number (______) ____

Payment Information

Annual $30 Membership Fee

☐ $30 check or money order enclosed and payable to OCA

☐ Please bill my credit card $30 ☐ VISA ☐Discover ☐MasterCard ☐American Express

Name on Card ____

Credit Card Number ____ Expiration Date _____/_____

☐ I understand I will be notified for annual renewals of Acclaim 30 days before my expiration date.

Signature ____ Original Application Date _____/_____/_____

Mail To: P.O. Box 2161 Broken Arrow, OK 74013-2161
Office: 405.767.1124 Fax: 405.767.5147
Email: acclaim04@yahoo.com