

PHE Discount Plan Application (Please Print)

FILL IN THE INFORMATION REQUESTED:

Date ____ / ____ / ____

First Name _____ MI ____ Last Name _____

Address _____

City _____ State _____ Zip _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

DISCOUNT HEALTH PROGRAMS:

Standalone Prescription Discount Card – Plan 5 \$1.54/mo

Pharmacy - Retail and Mail Order *

* Pharmacy discounts are not insurance and are not intended as a substitute for insurance.

ADDITIONAL TERMS AND CONDITIONS: To terminate or cancel the member agreement, please call (800) 800-7616 or send a written cancellation notice to New Benefits, 14240 Proton Road, Dallas, Texas, 75244. The notice must be submitted at least three (3) days prior to my next scheduled payment date. This agreement can be cancelled for non-payment.

Disclosures:

This plan is NOT INSURANCE. This discount card program contains a 30-Day cancellation period. Member shall receive a full refund of membership fees, excluding registration fee, if membership is cancelled within the first 30 days. The program and program administrators have no liability for providing or guaranteeing service and have no liability for the quality of service rendered. This contract is not protected by the Utah Life and Health Guaranty Association. Discount Medical Plan Organization, New Benefits, Ltd. 14240 Proton Rd. Dallas, TX 75244

SIGN HERE _____

signature required