

Discount Medical 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:

➤ **Enhanced Plan with PPO**

\$9.83/mo

- Chiropractic*
- Dental
- Doctors Online Plus
- Hearing Aids
- Pharmacy* - Retail and Mail Order
- Two-Blend PPO w/Medical Health Advisor*
- VIP Health & Wellness
- Vision

The Hospital program is not available in MD. Pharmacy discounts are not insurance and are not intended as a substitute for insurance. **The discount is only available at participating pharmacies. Dental, Physician Visit, Vision and Chiropractic Benefits are not available in Vermont.*

ADDITIONAL TERMS AND CONDITIONS: To terminate or cancel the member agreement, please contact your employer. The notice must be submitted at least three (3) days prior to the 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.

FL, LA, MS, ND, OK, RI, SC, SD and TX residents: Member shall receive a full refund of membership fees, excluding registration fee, if membership is cancelled within the first 30 days after the effective date. AR and TN residents: A refund of all fees will be issued if membership is cancelled within the first 30 days. MD Residents: The membership fee and one-time registration fee (minus \$5.00) will be refunded if cancelled within the first 30 days and upon return of the discount card. MA Residents: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00. Discount Medical Plan Organization: New Benefits, Ltd., Attn: Compliance Department, PO Box 671309 Dallas, TX 75367-1309. Not available in FL.

SIGN HERE _____

Signature required