LifeVantage Partners®

3500 Oak Lawn Ave Suite 395, Dallas, TX 75219
Customer Service: (800) 933-7231
Website: LIfeVantagePartners.com

New Application Submission Form

Scan then email applications MySHP@TeamSalesSupport.com

Producer Name: _____

Producer Phone: _____

Member Name	Payment Mode	Payment Amount

Since My LifeVantage Partners• is NOT Insurance, there are no forms to file and no waiting periods. My LifeVantage Partners• Is not sponsored by or endorsed by Medicare or any company. It Is not necessary to apply for any Insurance product as a prerequisite for My LifeVantage Partners• plan membership. A particular plan benefit may become unavailable in the future due to circumstances ***beyond the*** *control of My LifeVantage Partners• Copyright• LVP 2020*

Membership dues never increase, benefits(s) never decrease! Once joined, your dues are locked in so long as you continue to keep your membership in force. All future enhancements to any LifeVantage Partners Benefit Plan are included, upon request, at no additional cost to existing members!

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Member 1 Name:	Member 2 Name: (Paid-Up Only)	Member 1 Date of Birth:	Member 2 Date of Birth:
Member 1 Social Security#:	Member 2 Social Security#:	Member 1 Gender:	Member 2 Gender:
Mailing Address:	City:	Members Email Address:	
State and Zip Code:		Home Phone:	

Choose your Monthly Membership Benefits (check all that apply):

- O MY Universal Prescription Reduced Cost Benefit ($10)
- O MY Specialized Prescription Reduced Cost Benefits ($30)
- O MY Insulin & Diabetes Reduced Cost Benefits ($30)
- O MY Male Low-T + E.D. + Female E.O. Reduced Cost Benefit Program ($10 for all benefits!)
- O MY E.D. Prescription Drug Plan
- O MY Female E.O. Prescription Drug Plan
- O MY Pet Medication Plan ($10)
- O MY Chiropractic & Alternative Medicine ($10)
- O MY Eyewear & Vision Reduced Cost Benefits ($10)
- O MY Home Delivery Hearing Aid & Service Plan ($10)
- O MY Vitamin & Nutritional Supplements Plan ($10)
- O MY Viral-Protective Face Masks (New! Free with select Benefit Plans!!)
- O MY Dental & Dentures Reduced Cost Benefits ($30)

Choose Your Payment Mode:

(5 Payment Options: Monthly, $1299 / $1599 Paid-Up, 12-Month Paid-Up)

- ○ **Total Monthly Payments $**_____(recurring automatic monthly bank payment or annual bank pay)
- ○ **Single Payment of $1299.00 for ALL LifeVantage Benefits for one person** (all major credit cards accepted!)
- ○ **Monthly Bank Payments of $99.00 Includes all benefits one person. (Dental not Included)**
- ○ **Single Payment of $1599.00 for ALL LifeVantage Benefits for two people** (all major credit cards accepted!)
- ○ **12 Monthly Bank Payments of $129.00 Includes all benefits for two people. (Dental not Included)**

$1,299 / $1,599 Member Beneficiary - Who will receive your inheritance? *

Name (first, last):_____ Social Security:_____
Address:_____ Phone:_____
City, State:_____ Email:_____
*Beneficiary Information ONLY applicable to Paid-Up Members ($1299 / $1599 or 12-Month Paid-Up)

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Client Acknowledgement:

- I understand that My Life Vantage Partners, Inc. is **NOT** insurance.
- The plan is **NOT** sponsored or endorsed by Medicare or any insurance company.
- It is **NOT** required that I apply for any insurance product as a prerequisite for My Life Vantage Partners, Inc. plan membership.
- I understand a particular plan benefit may become unavailable in the future due to circumstances beyond the control of My Life Vantage Partners, Inc.
- Failure to utilize any or all of the items in the "Plan Description" for any reason does not entitle the customer to receive a refund of monies paid.
  - If in the unlikely event your desired Dental provider is not currently a member of our 100,000+ nationwide family of providers, you and/or your sales Consultant may contact us and simply request to nominate an additional provider. Members and Consultants may also do this via their website, https://www.memberproviders.com/SearchResults.aspx and clicking on the, "**Nominate a Provider**" section in the upper-right corner of the webpage. Although the vast majority of the time our Patriot Dental Benefit Program is successful adding requested provider nominees, there is no guarantee that the provider will subscribe to the program.
- These are service oriented plans and will not be refunded unless requested **prior to noon (Central Time) Wednesday after the date of this agreement**. After designated deadline, company will incur administrative costs and pre-purchase expenses.

NOTICE: You, the buyer, may cancel this transaction in writing, by phone, or by contacting the consultant prior to noon (Central Time) Wednesday after the date of this agreement and receive a full refund of all payments made. Refunds will not be issued if cancellation is made after the above-mentioned deadline.

**This plan will automatically renew at the end of the initial term at the corresponding monthly rate.*

CERTIFICATION

Your signature certifies that you have read and understand the terms of the MyLVP Plan Agreement and acknowledge that you have received a cop of this form.

Customer Signature: _____ Transaction Date: _____

Producer Signature: _____ Effective Date: _____

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BANK AUTHORIZATION
AGREEMENT FOR PRE-AUTHORIZATION BANK DEBIT

I hereby authorize My Life Vantage Partners, Inc., or its designee, to initiate debit entries and to initiate, if necessary, credit entries for my debit entries in error to my or the company's checking account and the bank, credit union, savings, etc. (as identified on the attached check payable to Life Vantage Partners or photocopied check).

Member Name: _____ **(Please Print)**

Choose Your Payment Mode (5 Payment Options: Monthly, $1299/$1599 Paid-Up, or 12-Month Paid-Up)
(5 Payment Options: Monthly, $1299 / $1599 Paid-Up, 12-Month Paid-Up)

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This authority is to remain in full force and effect until the company has received written notification from me or from the company of its termination in such time to afford the company and the depository a reasonable opportunity to act on it.

I understand that I may revoke these electronic funds transfer authorization by providing written notice to the company a least 5 business days prior to the payment due date. All payments listed above will have the payment debited by electronic funds transfer (EFT) on or after the date of this agreement listed to the right of the client's signature below.

PAYER APPROVAL:_____ **DATE:** _____

ATTACH VOIDED CHECK OR FILL IN THE ACCOUNT AND ROUTING NUMBERS BELOW

ACCOUNT NUMBER: _____

ROUTING NUMBER: _____

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Credit Card Authorization Form

I,_____hereby authorize My Life Vantage Partners, Inc. to charge my credit/debit card in the amount of $____.00. (Check one below)

Choose Your Credit Card Payment Amount

(2 Payment Options: $1299 or $1599 Paid-Up Plus One Beneficiary for Inheritance)

☐ **One Payment of $1299.00 for all MyLVP benefits for one person plus beneficiary***

☐ **One Payment of $1599.00 for all MyLVP benefits for two people plus beneficiary***

Credit Card Type: _____
(VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS)

Name (As it appears On Card):_____

Credit Card # _____-_____-_____-_____

Expiration: Date:____/_____(month/year)

Security Code (Last 3 numbers on back of card or 4 numbers on front for AMEX): _____

Cardholder Signature: _____

Today's Date: _____

OFFICE COPY

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(VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS)

Name (As it appears On Card):_____

Credit Card # _____-_____-_____-_____

Expiration: Date:____/_____(month/year)

Security Code (Last 3 numbers on back of card or 4 numbers on front for AMEX): _____

Cardholder Signature: _____

Today's Date: _____

CUSTOMER COPY

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