Individual, Family & Self-Employed -

DISCOUNT & SAVINGS MEDICAL PLAN - APPLICATION

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by | **Requested Effective Date of Coverage/Date of Change** / /

Name/Policy Number

Employer Name

Position/Title

Address:

Reason for Application

- ☐ *New Member*
- ☐ *Other*
- ☐ *Dependent Add/Delete*
- ☐ *Change Name/Address*

Enrollment Type

(Check all that apply)

- ☐ Individual
- ☐ Self-Employed
- ☐ Student
- ☐ Family
- ☐ Dependants
- ☐ Other _____

A. Applicant Information

Last Name	First Name	MI	Social Security Number	Home/Cell Phone Work Phone

Address	City	State	Zip Code	Language preference, if not English

Date of Birth / /	Sex ☐ M ☐ F	Height	Weight		Email Address

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Physician (PCP)* (First & Last Name)	Insurance Broker/Agent – Name DON MCCORMICK ID# Tel: 915-231-9955

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name First Name MI Social Security Number	Sex	Relationship***	Birth date				
_ _	☐M ☐F	Spouse					
_ _	☐M ☐F	Dependent					
_ _	☐M ☐F	Dependent					
_ _	☐M ☐F	Dependent					

*Important: For products, use First Health Network directory of providers to choose a Primary Care Physician for yourself and each of your covered dependents.

Network access provided by "First Health Network and Affiliates": Medical network provided by First Health Network (PPO, indemnity).

Discounted Products and Services (Not Insurance) Important notes about hospital discounts: The Discount program is not insurance and does not guarantee admission to a hospital or outpatient facility.

Applicant Name _____

C. Discount Plan Selection	Please check the box for each your dependents you are enrolling in. Zero $0 - Application and Administration Fee				
Person	**$65**	**$65**	**$65**	**Total Per Month**	**Total Monthly Membership Premium**
Individual or Self - Employed	■			■ $_____	■ $ _____
Spouse				■ $_____	■ $ _____
Dependent(s)				■ $_____	■ $ _____
Total Per Month	■ $_____	■ $_____	■ $_____	■ $_____	

D. Signature

I authorize Five Points Benefit Plans, LLC to obtain, use and disclose my medical, claim or benefit records including any individually identifiable health information contained in these records. In full compliance with HIPPA.

This plan is NOT Insurance

Discount Medical Plan Organization: : Five Points Benefit Plans, LLC
6006 N. Mesa St. – Suite 108
El Paso, Texas 79912

This plan provides discounts at certain healthcare providers for medical services. This plan does not make payments directly to the providers medical services. The plan member is obligated to pay for all health care services but will receive a discount from those healthcare providers who have contracted with the discount plan organization. Member shall receive a full refund of membership fees, excluding registration fee, if membership is cancelled within the first 30 days after receipt of membership materials. Available only in TX.

All benefits provided by this discount medical plan organization are subject to the terms, definitions, conditions, exclusions and limitations, of the group policy. To obtain more information about this Discount Plan, please ask to speak to a licensed agent. **THIS IS NOT BASIC HEALTH INSURANCE. THIS OFFER INCLUDES DISCOUNTS AND/OR SERVICES. NONE OF THESE, INDIVIDUALLY OR IN COMBINATION ARE A SUBSTITUE FOR BASIC HEALTH COVERAGE, MAJOR MEDICAL INSURANCE OR ANY OTHER MEDICAL EXPENSE REINBURSEMENT INSURANCE PLAN**. Actual cost and savings vary by provider and geographical area (According to the Aetna Enterprise Provider Database as of March 1, 2006).

One-time $25 Application and Administration Fee.

Make personal check payable to “Five Points MEC Plan.” If your are returning the completed application by mail, send to: Five Points Benefit Plans, LLC, 6006 N. Mesa St. - Suite 108, El Paso, Texas 79912. If you want to fax your application, please fax to: 1-915-519-0261, and mail your check to: Five Points Benefit Plans, LLC. 6006 N. Mesa St. - Suite 108, El Paso, Texas 79912.

Please maintain a copy of this enrollment for your records.

Date	Signature for all applying	Spouse Signature (if applying for coverage)

Discounted Products, Savings and Services (Not Insurance) Important notes about hospital discounts: The Discount program is not insurance and does not guarantee admission to a hospital or outpatient facility.

Auto-Recurring Payment Authorization Form

Credit Card Account

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

3 Digit Verification Code: _____

Type of Credit Card: **Master Card** ☐ **Visa** ☐ **Discover** ☐ **American Express** ☐

_____ _____

Signature of Enrollment Applicant Date

You authorize regularly scheduled monthly charges to your checking/credit card account. A receipt for each transaction will be automatically emailed to you with the contracted fee amount you have agreed too.

ACH Debit | Authorization Form

Five Points Benefit Plans, LLC

Payment Plan Authorization

Name: _____
Please print First Middle Last

Address: _____ Date of Birth: _____

City/State/Zip: _____ Last 4 digits of Social Security #: _____

Home Phone: (_____) _____ Driver's License #: N/A

Work Phone: (_____) _____ Driver's License State: N/A

Payment Plan Schedule

☐ One-time Payment Payment Amount: $_____ Payment Date: _____

☐ Recurring Debit every: _____ ☐ Day(s) ☐ Week(s) ☐ Month(s)

Start Date: Month: _____ Day: _____ Year: _____ Payment Amount: $_____
(Start date must be at least 15 business days from submission of this form)

End Date: Month: _____ Day: _____ Year: _____ Transaction Fee: $_____

Number of Payments: _____ Total Payment: $_____
(Payment Amount + Transaction Fee)

Customer Bank Account Information

Bank: _____ Phone Number: (_____) _____

Routing Number: _____

Account Number: _____

Attach a voided check to this form.

Payment Authorization

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (Minimum 30 days).

I understand that if the total amount owed to the Service Provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed the Service Provider is paid off, or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new ACH Debit Authorization Form.

All other changes such as payment amount, frequency, bank account number change, will require a new ACH Debit Payment Authorization Form to be filled out and submitted to Merchant 15 days prior to any change being implemented. I understand that this payment plan may be cancelled by the Service Provider or Merchant due to NSF (Non-sufficient Funds). I will be liable to pay an NSF fee of $25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and Merchant harmless from damage, loss or claim resulting from all authorized actions hereunder.

Customer Signature: _____ **Date:** _____

Second Authorized Signature of Bank Account if Required: _____ **Date:** _____

A voided check from customer's bank account must accompany this authorization form.