

AmeriPlan® Discount Programs Membership Application

If you are a current member of AmeriPlan® Corporation, please

enter your Member ID # M

Independent Business Owner #

Applicant First Name MI Last Name

Birth Date MO/DAY/YEAR Male/Female Home Telephone Work Telephone

Street Address Apt. #

City State Zip Code

LIST OF HOUSEHOLD MEMBERS E-MAIL ADDRESS:

Table with columns: FIRST NAME, LAST NAME, DATE OF BIRTH. Includes a box for listing additional household members on a separate page.

My membership is on an annual basis and all membership fees are non-refundable after 30 days.

I WANT TO PAY MY MONTHLY OR QUARTERLY MEMBERSHIP FEE BY: BANK DRAFT: Please Draft on the 3rd or 18th of the month. By submitting your enclosed check, you are authorizing the ongoing draft until AmeriPlan® is notified of cancellation in writing. X SIGNATURE FOR BANK DRAFT

CREDIT CARD: Visa MasterCard Discover American Express Credit Card Number Expiration Date X SIGNATURE FOR CREDIT CARD

MONTHLY OR QUARTERLY PAYMENTS MUST BE MADE BY ELECTRONIC BANK DRAFT OR BY CREDIT CARD. INVOICING IS AVAILABLE FOR ANNUAL MEMBERSHIPS ONLY WITH FIRST YEAR PAID IN ADVANCE.

AmeriPlan® Corporation 5700 Democracy Drive Plano, TX 75024 A Discount Medical Plan Organization AmeriPlan Health® is NOT insurance.



Membership Fees table with 4 choices: Choice #1 Dental Plus, Choice #2 Basic Health, Choice #3 Total Health, Choice #4 Total Health Plus. Includes registration fees and a total amount due section.

Enclose your check for payment and a voided check if paying monthly or quarterly by bank draft - 30-day written cancellation notice required.

OTHER MEMBERS OF THE HOUSEHOLD FIRST NAME LAST NAME DATE OF BIRTH

REFERRALS

AmeriPlan® is helping thousands of families save money. If you wish us to offer this opportunity to other people that you know, please fill out this referral form and we will contact them. Name Address City State Zip Code Telephone

FAX APPLICATION TO: 469-229-4589 OR 469-229-4590