ChiroHealthUSA ChiroHealthUSAPLUS

DISCOUNT MEDICAL PLAN APPLICATION

THIS FORM SHOULD NOT BE GIVEN TO PATIENTS UNLESS THEY ARE ENROLLING IN CHIROHEALTHUSA OR CHIROHEALTHUSAPLUS

You must read important disclosures and sign the reverse side

Date: _____

Patient Name:

_____

Primary Card Holder Gender: ___ Female ___Male

Primary Card Holder Date of Birth: _____

Dependents' Names: *(Spouse, Domestic Partner, Dependent Children up to age 26, Parents in the Household over age 60, and any other IRS Dependent)*

_____

_____

_____

_____

Patient Address:

_____

City:_____

State: _____ **Zip:** _____

Phone:

_____

Email:

_____

(Contact information will not be shared, sold or distributed)

Payment information:

Choose One:

__ YES! I want ChiroHealthUSA **PLUS** for $89.00 for a **ONE YEAR** membership to include Chiropractic, Vision, Dental, Pharmacy, Lab and Imaging Discounts! **NOTE**: Not available in Alaska, Vermont and Washington.

__ YES! I want ChiroHealthUSA for discounted Chiropractic Care Only for $49.00 for a **ONE YEAR** membership.

You may renew your agreement by continuing annual payments as applicable for your plan. The brochure for your program contains a description of the benefits you will receive and is incorporated by reference and is a part of this document. PLEASE READ YOUR BROCHURE BEFORE SIGNING THIS DOCUMENT.

HSA and FSA accounts for payment of membership fees is not permissible.

Check #:_____

Credit card information will be destroyed once transactions completed.
Credit Card Type: Visa__ MC__ Amex__ Disc.__

Card#:_____ Card ID (CVV2/CID) Number: _____

Exp. Date: _____ Billing Zip Code: _____

Name on card: _____

Signature: _____

FOR CLINIC USE ONLY:
Provider Name: _____
Date entered in Online Membership Link: _____ By: _____

Disclosures: **These discount medical, health, and drug plans are NOT insurance, health insurance policies, Medicare Prescription Drug Plans or qualified health plans under the Affordable Care Act. These plans (The Plans) provide discounts for certain medical services, pharmaceutical supplies, prescription drugs or medical equipment and supplies offered by providers who have agreed to participate in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). The range of discounts for medical, pharmacy or ancillary services offered under The Plans will vary depending on the type of provider and products or services. The Plans do not make and are prohibited from making members' payments to providers for products or services received under The Plans. The member is required and obligated to pay for all discounted prescription drugs, medical and pharmaceutical supplies, services and equipment received under The Plans, but will receive a discount on certain identified medical, pharmaceutical supplies, prescription drugs, medical equipment and supplies from providers in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). Members will have free access to providers without restrictions such as waiting periods, notification periods, etc. except for hospital discounts. The Plans do not offer discounts on hospital services. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., P.O. Box 610810, Dallas, TX 75261. ChiroHealthUSA members may call 1-888-719-9990 for more information or visit www.chirohealthusa.com for a list of providers. ChiroHealthUSA Plus members may call 1-800-220-7752 for more information or visit www.chirohealthusaplus.com for a list of providers. The Plans will make available before purchase and upon request, a list of program providers and the provider's city, state and specialty, located in the member's service area. Alliance HealthCard of Florida, Inc. does not guarantee the quality of the services or products offered by individual providers. The fees for The Plans are specified in the membership agreement. You have the right to cancel your membership at anytime. If you cancel your membership within 30 days of the effective date, you will receive a full refund of your membership fees other than money paid by you to a provider. To cancel your ChiroHealthUSA Plan you must, verbally or in writing, notify ChiroHealthUSA at 1-888-719-9990, 120 Stone Creek Blvd., Suite 100, Flowood, MS 39232. To cancel your ChiroHealthUSAPlus Plan you must, verbally or in writing, notify Alliance HealthCard of Florida, Inc. at 1-800-220-7752, P.O. Box 610810, Dallas, TX 75261. Any complaints should be directed to Alliance HealthCard of Florida, Inc. at the address or phone number above. Upon receipt of the complaint, member will receive confirmation of receipt within 5 business days. After investigation of the complaint, Alliance HealthCard of Florida, Inc. will provide member with the results and a proposed resolution no later than 30 days after receipt of the complaint.**

Note to DE, IL, LA, NE, NH, OH, RI, SD, TX and WV consumers: If you remain dissatisfied after completing the complaint system, you may contact your state department of insurance . You may contact Alliance HealthCard of Florida, Inc. for department of insurance contact information.

Note to MA consumers: 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

Signature: _____