



DISCOUNT MEDICAL PLAN APPLICATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone: (____) _____

Step 1: Select the products you wish to purchase from the list below.

PROVIDENCE PLAN

____ Annual Membership \$99.00

____ Monthly Membership \$9.95

Offers savings of:

- Save an average of 20% on prescription medications
• 10-50% on dental work
• 20-60% on vision care eyewear
• 20-40% on chiropractic care
• 10-20% on hearing care
• 20% on alternative and complementary medicines and therapies

OTHER

____ Additional Card \$5.00/card Qty

____ Additional Card \$5.00/card Qty

PROVIDENCE PLAN PLUS

____ Annual Membership \$129.00

____ Monthly Membership \$14.95

Offers savings of:

- Save an average of 20% on prescription medications
• 10-50% on dental work
• 20-60% on vision care eyewear
• 20-40% on chiropractic care
• 10-20% on hearing care
• 20% on alternative and complementary medicines and therapies
• 5-40% Hospital and Physician Referral

Step 2: Select just one of the payment options listed below by marking the appropriate box:

DIRECT BILL PAYMENT OF PROVIDENCE PLAN

- Annual Membership - I have enclosed a check or money order for \$99.00 made payable to Providence Plan.
Monthly Membership - I have enclosed a check or money order for \$9.95 which is my first month payment of membership made payable to Providence Plan. I will be billed \$9.95 monthly for my continuing membership.

DIRECT BILL PAYMENT PROVIDENCE PLAN PLUS

- Annual Membership - I have enclosed a check or money order for \$129.00 made payable to Providence Plan.
Monthly Membership - I have enclosed a check or money order for \$14.95 which is my first month payment of membership made payable to Providence Plan. I will be billed \$14.95 monthly for my continuing membership.

Step 3: Mail this form and your check or money order to:

PROVIDENCE PLAN
PROCESSING CENTER
5100 N O'connor Blvd, Ste 600
Irving, TX 75039

THIS IS NOT INSURANCE The plan provides discounts at certain health care providers for medical services. The plan does not make payments directly to the providers of medical services. The plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount medical plan organization. The range of discounts for services offered will vary depending on the type of provider and service. This is not a Medicare prescription drug plan. Discounts on hospital services are not available in Maryland. This plan is administered by Coverdell & Company, Inc., a DMPO, 8770 W. Bryn Mawr, #1000, Chicago, IL 60631, 800-308-0374. You have the right to cancel this plan within 30 days of the effective date for a full refund of fees paid. Note to Texas Consumers: Regulated by the Texas Department of Licensing and Regulation, PO Box 12157, Austin, TX 78711; 800-803-9202 or (512) 463-6599; www.license.state.tx.us/compliants. You may terminate this agreement and your membership at any time. Your cancellation will be effective promptly upon the receipt of your cancellation notice and you will no longer be billed for your membership within 30 days of receipt of request. Note to West Virginia Consumers: If you remain dissatisfied after completing the general complaint procedure, you may contact the Offices of the West Virginia Insurance Commissioner.