



PROVIDENCE PLAN DISCOUNT MEDICAL PLAN APPLICATION

First Name: _____ Last Name: _____

Mailing 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:

- Up to 30% on prescription medications
- 10-50% on dental work
- 20-60% on vision care eyewear
- 20-40% on chiropractic care
- 10-20% on hearing care
- 10-30% 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:

- Up to 30% on prescription medications
- 10-50% on dental work
- 20-60% on vision care eyewear
- 20-40% on chiropractic care
- 10-20% on hearing care
- 10-30% on alternative and complementary medicines and therapies
- Hospital and Physician Referral

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

CREDIT CARD VISA MASTERCARD DISCOVER

Name as it appears on card: _____

Account #: _____ Expiration Date: ____/____/____

SIGNATURE _____ DATE: _____

I authorize **Providence Plan** to charge my account in the amount(s) selected above

BANK DRAFT

I authorize **Providence Plan** to debit my account in the amount(s) I have selected above.

Checking Account Savings Account Bank Name: _____

Routing #: _____ Account #: _____

I have completed the information above, or enclosed a voided check that will be provided to my bank to initiate the automatic draft process.

SIGNATURE _____ DATE _____

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, P.O. BOX 192008, DALLAS, TX 75219**

THIS IS NOT INSURANCE

This plan is administered by Coverdell & Company, Inc., a discount medical plan organization at 8420 W. Bryn Mawr, Suite 700, Chicago, IL 60631, 1-800-308-0374.

Providence Plan is not available to residents of Vermont or Connecticut