



MediClassic[®]

ENROLLMENT FORMS
CHOICE PLAN



South Florida Prepaid Health Clinics, Inc.

Member Application & Status Change Form

Individual(s) applying for prepaid health clinic coverage must answer all questions completely in Sections I through IV. A Member who needs to change the information originally provided in his or her application must complete Section V only.

Part I. Subscriber Information

Last Name	First Name	MI	Birth Date	Age	Sex	Marital Status

Street Address	City	State	Zip Code	County

Social Security Number	Telephone Number	Primary Care Physician Name & Number

Part II. Dependent Information (use additional paper if necessary). A dependent who qualifies for coverage will be issued his or her own coverage plan and Member identification number. Eligible dependents are the Subscriber's lawful spouse and the Subscriber's natural child, adopted or foster child, step-children or any other child living in a normal parent-child relationship and whom the Subscriber claims as a dependent on his or her federal income tax return.

Full Name	Social Security #	Sex	Birth date	Primary Care Physician Name & Number
Spouse				
Dependent*				
Dependent*				
Dependent*				

Part III. Other Health Coverage Information

Is Spouse Employed?	If yes, Spouse's Employer (Name & Address)	
Do you or your spouse have other health coverage?	If yes, Name, Address and Policy # of Insurance Carrier or HMO providing coverage.	Are you or any of your dependents covered under your Spouse's coverage or any other Insurance including Medicare or Medicaid?

If you have answered yes to having other coverage, will coverage(s) be terminated if this coverage is issued? If yes, identify the coverage(s) to be terminated _____

Part IV. Authorization

If I have elected coverage: (1) I authorize any physician or other health care provider or facility or any other entity having any information as to me or my health or that of my dependents, to provide to South Florida Prepaid Health Clinics, Inc. (SFPHC), and/or its contracted providers or review organizations information concerning health care advice, treatment or supplies provided my dependents and/or myself relating to coverage under this prepaid health clinic plan. This information may be used for determining eligibility, coordinating patient care, evaluating and administering claims for benefits, satisfying other business requirements in connection with the relationship and fulfilling obligations imposed on SFPHC by federal or state law. The information requested by SFPHC may include information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including consultations after the date this authorization is signed. Any other information SFPHC believes to be necessary to determine eligibility for benefits may also be requested. (2) I certify that I have read the statements on this form or that they have been read to me, and that all the information was provided by me and is true and complete to the best of my knowledge. I understand that any intentional material misrepresentation or material omission contained herein may be used to reduce or deny a claim or void the coverage provided under this Plan. I further understand that no agent can modify this application, waive the answers to any questions, or suggest or complete the answers thereto. (3) This authorization may be withdrawn by me at any time, but will otherwise continue to be valid during the entire term of my enrollment in this prepaid health clinic plan. A facsimile of this signed authorization shall be as valid as the original.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicant's Signature	Date
Agent's Signature	Date

Part V. Member Change Information

Member's Name and Identification Number	
Identify type of change and provide the additional information requested in the space provided.	
Change Type: _____ Cancel SFPHC Coverage (provide date You want Coverage to terminate) _____ Termination of Other Insurance Coverage (insert Carrier Name and Type of Coverage) _____ Purchase of Other Insurance Coverage (provide Carrier Name and Type of Coverage) _____ Address Change (provide new address, state, zip code and county) _____ Phone Number change (provide new phone number) _____ Other (please explain below)	
_____ _____ _____ _____	
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.	
Applicant's Signature	Date



Prescription Coverage Application

Part I. Subscriber Información / Información del Solicitante

Last Name/Apellido	First Name/Primer Nombre	Middle Initial/Inicial	Birthdate/Fecha de Nacimiento	Marital Status/Estado Civil	
Street Address/Dirección Permanente		City/Ciudad	State/Estado	Zip Code/Código Postal	County/Condado
Social Security Number/Numero Seguro Social		Telephone Number/Numero de Teléfono			
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Part II. Dependent Información/Información Sobre Los Dependientes

Full Name Nombre Completo	Birthdate/ Fecha de Nacimiento	Social Security # Numero de Seguro Social
Spouse/Cónyuge		
Dependent/Dependiente		
Dependent/Dependiente		
Dependent/Dependiente		
Applicant's Signature/Firma del Solicitante		Date/Fecha
Agent's Signatura/Firma del Agente		Date/Fecha



South Florida Prepaid Health Clinics, Inc.
2600 Douglas Rd. Ste #400 Coral Gables Fl. 33134

DIRECT DEBIT AUTHORIZATION

Member's Name: _____ **Social Security No:** _____

Address: _____ **Business Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **E-Mail:** _____

I (We), the above named member(s), do hereby authorize (a) South Florida Prepaid Health Clinics, Inc. (SFPHC), to initiate debit entries to my (our) account indicated below to pay the premiums and other charges, such as non-sufficient funds, due on any insurance policy issued pursuant to the application which accompanies this statement, and (b) the Financial Institution named below (INSTITUTION) to debit my (our) account for such amounts, as indicated below (Selected Plan Option).

Selected Plan Option:

Monthly
\$ _____ **Premium MediClassic**
\$ _____ **Premium Prescription**
\$ _____ **Total Recurring Debit Total**

I understand that the effective date of coverage applied for is the first of the month following the date the application was signed, and that no benefits will be paid until after the stated effective date as indicated in the issued policy or until any applicable waiting period has been satisfied. I understand that there is an administrative fee of \$3.00 that is applied on a monthly basis as indicated above.

The term "debit entry" shall include charges to my (our) account by orders initiated by electronic means, checks, drafts or any other order. I agree that a photographic copy of this agreement shall be as valid as the original.

I (we) have the right to stop payment of a debit entry by giving notice to INSTITUTION in such time as to afford INSTITUTION a reasonable opportunity to act prior to charging my (our) account. After my (our) account has been charged, I (we) have the right to have the amount of an erroneous debit immediately credited to such account by INSTITUTION up to 15 days following issuance of statement or 45 days after posting, whichever comes first.

INSTITUTION'S treatment of each account debit, check draft or other order initiated by SFPHC, and its rights with respect to it will be the same as if it were signed personally by me (us). If any such debit entry is dishonored for any reason, INSTITUTION will not be under any liability even though dishonor results in the forfeiture of insurance.

IT IS UNDERSTOOD THAT ALL DEBIT ENTRIES INITIATED BY SFPHC PURSUANT TO THE AGREEMENT SHALL BE SUBJECT TO THE FOLLOWING PROVISIONS:

This agreement shall not be effective until accepted by SFPHC.

SFPHC may initiate an entry that is larger than the next previous entry, or may change the date of the billing cycle, providing SFPHC tells me (either of us) in writing about the increase or the new date at least ten (10) days before charging the larger amount to my (our) account or making the first entry to be affected by the new date.

SFPHC will not send premium notices. Periodic statements, cancelled checks or other orders received by me (either of us) from INSTITUTION will be my (our) receipt.

This agreement will end when (a) SFPHC receives a written request from me (either of us) to end it, or (b) when SFPHC or INSTITUTION sends me (either of us) written notice ten (10) days prior to SFPHC'S or INSTITUTION'S termination of the Agreement.



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This agreement may be ended automatically by SFPHC if any debit entry has been refused by INSTITUTION because of insufficient funds in my (our) account,

Signature of Member: _____ **Date** _____

Make Checks Payable To: South Florida Prepaid Health Clinics, Inc.

Automatic Bank Draft-Name of Bank: _____

Routing No.: _____ Checking Account No.: _____

Your Direct Debit will be drafted on the _____ of each month.

Account Holder's Signature: _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive any provider, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree

ATTACH VOIDED CHECK HERE



Payment Plan Transmittal

<i>Language Choice:</i> <input type="checkbox"/> English <input type="checkbox"/> Español	
Monthly Plan Premium + Monthly Premium Prescription + Administration Fee + Application Fee + (do not include fee in debit authorization)	\$ _____ \$ _____ \$ <u> 3 </u> \$ <u> 35 </u>
Total Funds Collected = \$ _____	
<input type="checkbox"/> Direct Debit <input type="checkbox"/> Coupon Payments <input type="checkbox"/> Personal Check <input type="checkbox"/> Cash <input type="checkbox"/> Money Order Please include the Following: Debit Authorization Form Copy of Voided Check	
Lead #	
Member's Name:	Proposed Effective Date
Members Signature	Date
Writing Agent's Name	Referral Agent's Name
Agent's Signature	Date
Agent's License #	State FLORIDA
Make Checks Payable To: South Florida Prepaid Health Clinics, Inc.	

This form must be presented together with the member's application to South Florida Prepaid Health Clinics, Inc.



Please, place your initials in the following statements:

_____ Have you read "LEARN MORE ABOUT THE PLAN" ?

_____ Did you receive the Summary of Benefits?

_____ Did you receive a Provider Directory?

_____ Did you receive the agent's business card?

Agent's Name

Member's Name

Agent's Signature

Member's Signature