americancare.net
American Care

11255 SW 211 Street / Miami, FL 33189-2240 / 1-888-777-2555
www.premierplans.org / www.americancare.com

APPLICATION FORM TO PARTICIPATE IN THE PREMIER PLANS PROGRAM
AMERICAN CARE, INC. DISCOUNT MEDICAL PLAN ORGANIZATION

Part I. Member Information

Last Name	First Name	MI	DOB	AGE	M/F	Marital Status

Address	City	State	Zip

Home Phone	Work/Cell Phone	S.S. Number	E-Mail Account

NOTICE: "THIS PLAN IS NOT A HEALTH INSURANCE POLICY. THIS PLAN PROVIDES DISCOUNTS AT HEALTH CARE PROVIDERS FOR CERTAIN MEDICAL SERVICES. THIS PLAN DOES NOT MAKE PAYMENTS DIRECTLY TO THE PROVIDERS OF MEDICAL SERVICES. PLAN MEMBERS ARE OBLIGATED TO PAY FOR ALL HEALTH CARE SERVICES, BUT WILL RECEIVE A DISCOUNT FROM THOSE HEALTH CARE PROVIDERS WHO HAVE CONTRACTED WITH AMERICAN CARE, INC." American Care, Inc. – Premier Plans, 11255 SW 211 Street, Miami, Florida 33189-2240.

Part II. Payment Information

Processing non-refundable fee: all contracts have a one-time payment of $30.00 (due at time of contracting).

Monthly Payments
A membership fee of $30.00 per member per month. Due the first of every month.

Payment Information: ( ) Automatic electronic withdrawal with the attached agreement.
( ) Monthly Check or Money Order.

MEMBER CHARGE	$	30.00
	$	
Initial Processing Fee	$	30.00
TOTAL DUE AT CONTRACTING	$	
MONTHLY CHARGE	$	

Part III. Authorization

I hereby agree to the terms and conditions of American Care, Inc.'s Discount Medical Plan Organization contract and its agreement to participate in the Premier Plan program. I will receive forms, information, and list of providers through the American Care, Inc.'s Member Services Department and/or through the website for the Premier Plan program: **www.premierplans.org**. I understand that if I request information, it will be sent to me via U.S. regular mail. I further understand that no agent can modify this application, waive the answers to any questions, or suggest or complete the answers thereto. I attest and certify that all information provided by me has been accurate, complete, and not misrepresented, and that I have read the statements in this form or that they have been read to me and that all material misrepresentation or material omissions contained herein may be used to terminate participation in the program. I submit this application knowing that any person who knowingly and with intent to injure, defraud, or deceive any company licensed by the Florida Office of Insurance Regulations that 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 Name (Printed)	Applicant's Signature (Black Ink)	DATE

>	>	>	>
Agent's Name (Printed)	Agent's Number	Agent' Signature	DATE

Authorization Agreement for ACH debits and Credit Card Charges

American Care, Inc. 11255 SW 211 Street, Miami, FL 33189-2240, Tax ID Number 65-0712890

I (We) hereby authorize American Care, Inc., hereinafter called American Care, to initiate debit entries and/or correction entries and/or credit card changes to our: ☐ Checking Account ☐ Savings Account ☐ Credit Card

Indicated below at the depository/credit card company named below, hereinafter called DEPOSITORY/CREDIT CARD COMPANY, to credit the same such account. I (We) acknowledge that the origination of the ACH transactions or credit card charges to my (our) account must comply with the provisions of U. S. law.

DEPOSITORY

DEPOSITORY NAME

BRANCH

CITY STATE

ACCOUNT NUMBER

BANK TRANSIT / ABA NUMBER

CREDIT CARD

☐ AMERICAN EXPRESS

☐ MASTERCARD ☐ VISA

NAME AS IT APPEARS ON THE CARD

ACCOUNT NUMBER EXPIRATION DATE

CID NUMBER

This authorization is to remain in full force until American Care has received written notification from me (or either of us) of its termination in such time and in such manner as to afford American Care and DEPOSITORY / CREDIT CARD COMPANY reasonable opportunity to act upon it.

NAME	SIGNATURE
SOCIAL SECURITY NUMBER	DATE
NAME	SIGNATURE
SOCIAL SECURITY NUMBER	DATE