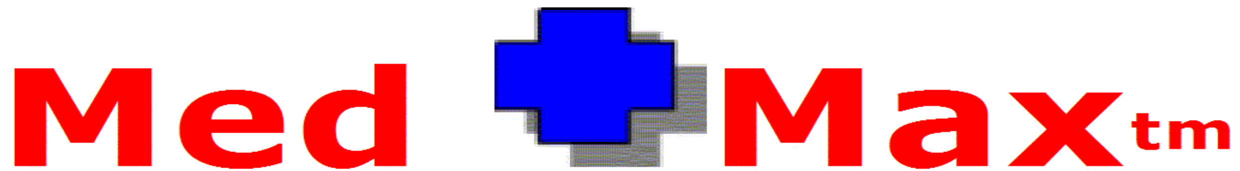

Critical Illness Application Submittal

Date:

Member ID:

Member's Name:

Agent Code:

Agent Name:

Please review checklist before you send the Enrollment Application

- ❑ Applicant must complete **Section I** (Enrollment Form).
- ❑ Agent must complete first part of **Section II** and sign (Billing Form).
- ❑ Applicant must complete the rest of **Section II** (Billing Form).
- ❑ Paying via check: Make check payable to **MEDMAX.**
- ❑ Paying via EFT: Include copy of a voided check with Enrollment Application.
- ❑ **No charge** for monthly Electronic Fund Transfers (EFT).
- ❑ Monthly invoices are subject to a **$10.00** Billing Fee. (Groups Only)
- ❑ Must pay first month's (premium, admin fee & one time enrollment fee).
  (Association dues are charged on the 1st day of every year. $20 individuals, $30 all others)
- ❑ Application must be received by the **15th** of prior month to be approved for the 1st of the following month.
- ❑ **Paying via check:** Mail completed Enrollment Application to:
  MEDMAX
  PO Box 297375
  Pembroke Pines, FL 33029-7375
- ❑ **Paying via EFT:** Scan and Email or Fax completed Enrollment Application to:
  health@medmaxinsurance.com
  1-561-829-7181
  Attn: Enrollment Department

If you need assistance filling out the Enrollment Application, please contact your agent or broker.

Agent/Broker **Telephone:**

A Defined Benefit Health Insurance Plan for CPAI Members

Not a Major Medical Health Plan

This product is administered for CPAI by
MedMax
PO Box 297375
Pembroke Pines, FL 33029-7375

ENROLLMENT APPLICATION – Critical Illness

Office use only:

Name of Group		Group Number		
Effective Date	Date Submitted	Approved By:	Processed By:	Date Processed:

SECTION I – Enrollment Form – FORM MUST BE FILLED OUT IN BLACK INK – PLEASE PRINT CLEARLY

APPLICATION TYPE ❑ **OPEN ENROLLMENT** ❑ **ENROLLMENT CHANGE** ❑ **TERMINATION**

(Check Appropriate Box)

REQUESTED EFFECTIVE DATE ___________________________

first day of (mmddyyyy)

(Check Appropriate Box)

APPLICANT NAME Last, First, Middle Initial)		GENDER ❑ Male ❑ Female		BIRTHDATE (mmddyy)	SOCIAL SECURITY NO.
STREET ADDRESS		CITY		STATE	ZIP CODE
BILLING ADDRESS / CONTACT / COMPANY (If different than above)					EMAIL ADDRESS
HOME PHONE	WORK PHONE	MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed			

Note: If you are applying for coverage for your spouse and/or children, please list each one below – see Election of Coverage for eligibility.
Please indicate additional dependants on a duplicate sheet

LAST NAME FIRST NAME	RELATION	GENDER	SOCIAL SECURITY NUMBER	BIRTHDATE MMDDYYYY	Check if over 19 & disabled	
SPOUSE	❑ WIFE ❑ HUSB.	❑ M ❑ F				
DEPENDENT	❑ SON ❑ DAUG.	❑ M ❑ F				
DEPENDENT	❑ SON ❑ DAUG.	❑ M ❑ F				
DEPENDENT	❑ SON ❑ DAUG.	❑ M ❑ F				
DEPENDENT	❑ SON ❑ DAUG.	❑ M ❑ F				

ELECTION OF COVERAGE AND AUTHORIZATIONAUTHORIZATION*

The applicant in consideration of membership in the Association and participation in the plan hereby acknowledges that the Association, its third party administrator, their agents, owners, successors and assigns assumes no liabilities or obligations other than those specifically identified. I hereby agree to indemnify them from and against any and all claims, damages, losses, costs or expenses (including without limitation, attorneys fees and disbursements) for any claims that may arise by the participation of the plan or membership in the association. All information provided above is true and complete to the best of my knowledge. My signature below also indicates I would like to enroll in the Rx plan I selected above. All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage. It will take one week after your effective date for your cards and provider books to arrive.

APPLICANT SIGNATURE (REQUIRED)	PRINT NAME	DATE
X		

SECTION II – Billing Form

Rep Name	Rep Signature	Date	Telephone	Rep Code

Med+Max Critical Illness

Enrollment Worksheet

SELECT MONTHLY PREMIUM (Check Appropriate Box)	**Critical Illness**
$2,500 Critical Illness	❑ $8.60
$5,000 Critical Illness	❑ $14.20
$10,000 Critical Illness	❑ $25.40
$25,000 Critical Illness	❑ $52.10

Step 1. Enter Rate Selected Above: $ _____________ times number of persons in the plan ________= $ ________________

Step 2. Monthly administration fee: $ 0.00

Step 3. One time enrollment fee: $ 25.00

Step 4. Total Contribution at Enrollment —— **Add steps 1 – 3:** $ ________________

PAYMENT OPTIONS (Check Appropriate Box Below)

❑ ELECTRONIC FUNDS TRANFER **(Fill out EFT Authorization Form below)**

INITIAL PAYMENT: Please EFT my bank account for first month's premium, administration fee, and one time enrollment fee. This will occur between the 15th & 20th of the month prior to the effective date **(voided check is required & must be legible).**

MONTHLY PAYMENT: Please EFT my bank account for the monthly premium and administration fee, and my annual association dues. This will occur between the 15th and the 20th of the month prior to the next month's coverage. **(no monthly charge for EFT).**

❑ CHECK OR MONEY ORDER **(Make payable to MEDMAX) Groups Only**

INITIAL PAYMENT: I am paying my first month's premium, administration fee, and one time enrollment fee via check/money order. I am sending my check or money order with my completed Enrollment Form. **There is a $30 insufficient funds fee.**

MONTHLY PAYMENT: I would like to receive a monthly invoice to pay my monthly premium and administration fee, and my annual association dues. I understand an additional monthly fee of $10 will be charged to me to receive a monthly invoice.

APPLICANT SIGNATURE (REQUIRED)	PRINT NAME	DATE
X		
ACCOUNT HOLDER SIGNATURE (REQUIRED if paying via EFT)	PRINT NAME	DATE
X		

EFT AUTHORIZATION FORM

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER

Voided check is **required** and must be legible. **No monthly charge for EFT**.

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to MEDMAX three days or more before this payment is scheduled to be made. Please be aware that your bank statement will reflect the debit as MEDMAX.

ACCOUNT HOLDER SIGNATURE (REQUIRED)	PRINT NAME	DATE
X		

SECTION II – Billing Form (continued) – *Use this page only when paying with credit cards*

❑ CREDIT CARD **(Fill out Authorization Form below)**
INITIAL PAYMENT: Please charge my Credit Card for first month's premium, administration fee, and one time enrollment fee.
This will occur between the 15th & 20th of the month prior to the effective date.

MONTHLY PAYMENT: Please charge my Credit Card for the monthly premium and administration fee, and my annual association dues (included on my January payments only).
This will occur between the 15th and the 20th of the month prior to the next month's coverage. **There is a $30 credit card declined fee.**

CREDIT CARD AUTHORIZATION				
ACCOUNT HOLDER NAME (as it appears on the card)		❑VISA ❑Master ❑Amex ❑Discover		
BILLING ADDRESS		CITY	STATE	ZIP
CREDIT CARD NUMBER	EXPIRATION DATE	EMAIL ADDRESS		
PHONE	FAX	SIGNATURE OF CARDHOLDER		DATE
THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE UNTIL MEDMAX HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD MEDMAX REASONABLE OPPORTUNITY TO ACT UPON IT.				