



Insurance 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 **Insurance Resource Group**.
- Paying via EFT: Include copy of a voided check with Enrollment Application.
- Monthly invoices are subject to a **\$10.00** Billing Fee. (Groups Only)
- No charge** for monthly Electronic Fund Transfers (EFT).
- 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 MEDMAX by
Insurance Resource Group
20 Madison Avenue
Valhalla, New York 10595

po box 297375
pembroke pines, fl 33029-7375

ENROLLMENT APPLICATION

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)

LEVEL OF COVERAGE PLANS I, II & III SINGLE SINGLE+1 SINGLE+2 OR MORE

LEVEL OF COVERAGE PLAN IV SINGLE SINGLE+SPOUSE SINGLE+CHILD(REN) FAMILY

SELECT MEDICAL PLAN PLAN I (Silver) PLAN II (Gold) PLAN III (Diamond) PLAN IV (Plus)

PROVIDER NETWORK MULTI PLAN PPO REQUESTED EFFECTIVE DATE _____
first day of (mmdyyyy)

APPLICANT NAME Last, First, Middle Initial		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (mmdyyy)	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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		DATE of EVENT (If applic.)
EMERGENCY CONTACT (Name)		RELATION	CONTACT NUMBER	ALTERNATE CONTACT NUMBER

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		<input type="checkbox"/> WIFE <input type="checkbox"/> HUSB.	<input type="checkbox"/> M <input type="checkbox"/> F			
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F			
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F			
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F			
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F			

Are you covered by any other health insurance plan? YES NO (If yes indicate below) Is your spouse covered by any other health insurance plan? YES NO (If yes indicate below)

INSURANCE COMPANY NAME	POLICY NUMBER	INSURANCE COMPANY NAME	POLICY NUMBER
ADDRESS	EFFECTIVE DATE	ADDRESS	EFFECTIVE DATE

ELECTION OF COVERAGE AND AUTHORIZATION*

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. I understand that pre-existing conditions will not be covered during the first twelve months of the contract unless I present evidence of prior creditable coverage. All information provided above is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. Disclaimer **IMPORTANT!** Our plan is a low-cost alternative, providing medical insurance at fixed amounts, and these **limited benefits** are paired with medical discounts to designated providers. My signature below indicates that the limitations of the plan have been discussed and explained to me and that I understand and accept said plan designs. My signature below also indicates I would like to enroll in the limited health 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) X	DATE
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ACCEPTANCE AND AGREEMENT NOTICE: Submission of Employer Application does not initiate coverage. Coverage is subject to approval prior to initiation. Enrollees will be issued individual policies and/or certificates of insurance. Minimum participation may be required. In the event that participation is not met, coverage will not take effect. Your coverage will begin on the first day of the month following receipt of the Enrollment Form. This is a limited benefit policy and is not a substitute for a major medical plan.

APPLICANT SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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SECTION II – Billing Form

Rep Name	Rep Signature	Date	Telephone	Rep Code
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Med+Max Health Benefits

Enrollment Worksheet

Effective 12/1/2008 (Includes PPO Network Charge)

SELECT MONTHLY PREMIUM PLAN	SINGLE	SINGLE + 1	SINGLE + 2+	EE + SPOUSE	EE+CHILD(REN)	FAMILY
PLAN I SILVER	<input type="checkbox"/> \$190.96	<input type="checkbox"/> \$286.80	<input type="checkbox"/> \$382.65			
PLAN II GOLD	<input type="checkbox"/> \$242.07	<input type="checkbox"/> \$380.99	<input type="checkbox"/> \$519.91			
PLAN III DIAMOND	<input type="checkbox"/> \$283.97	<input type="checkbox"/> \$450.90	<input type="checkbox"/> \$618.90			
PLAN IV PLUS	<input type="checkbox"/> \$353.89			<input type="checkbox"/> \$654.43	<input type="checkbox"/> \$583.39	<input type="checkbox"/> \$854.47
Step 1. Enter Premium Selected Above						\$ _____
Step 2. Critical Illness Options						
Silver Critical Illness Dep. 2.5K		<input type="checkbox"/> \$4.80				
Gold Critical Illness Dep. 5K		<input type="checkbox"/> \$9.60				
Diamond Critical Illness Dep. 10K		<input type="checkbox"/> \$19.20				
Silver increase Critical Illness to 25K	<input type="checkbox"/> \$43.30	<input type="checkbox"/> \$91.40				
Gold increase Critical Illness to 25K	<input type="checkbox"/> \$38.50	<input type="checkbox"/> \$86.60				
Diamond increase Critical Illness to 25K	<input type="checkbox"/> \$28.90	<input type="checkbox"/> \$77.00				
Plus increase Critical Illness to 10K	<input type="checkbox"/> \$9.60			<input type="checkbox"/> \$19.20		
Plus increase Critical Illness to 25K	<input type="checkbox"/> \$38.50			<input type="checkbox"/> \$77.00		
Step 3. Optional Prescriptions Rider	<input type="checkbox"/> \$19.95	<input type="checkbox"/> \$26.95	<input type="checkbox"/> \$28.95	<input type="checkbox"/> \$24.95	<input type="checkbox"/> \$26.95	<input type="checkbox"/> \$28.95
Step 4. Optional Accident Rider	<input type="checkbox"/> \$16.15	<input type="checkbox"/> \$21.50	<input type="checkbox"/> \$24.00	<input type="checkbox"/> \$19.00	<input type="checkbox"/> \$21.50	<input type="checkbox"/> \$24.00
Step 5. One time enrollment fee						\$ 60.00

Step 6. Total Contribution at Enrollment — Add steps 1 – 5: \$ _____

PAYMENT OPTIONS (Check Appropriate Box Below)

- ELECTRONIC FUNDS TRANSFER (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**
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. (Groups Only)**

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

EFT AUTHORIZATION FORM

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER
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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 I.R.G-HEALTH.

ACCOUNT HOLDER SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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