Detach the completed pink form. Insert form in pre-paid envelope and drop in the mail

AmeriPlan USA Enrollment Application
Dental-Vision-Prescription-Chiropractic Plan

Enrolling Broker Number 4 0 0 8 5 1 8 8

First Name | MI | Last Name

Date of Birth of Applicant | Male/Female | Social Security # | Residence or Work Telephone

Mailing Address | Apt.#

City | State | Zip | Applicant's Employer

LIST OF HOUSEHOLD MEMBERS

E-MAIL ADDRESS

First Name	Last Name	Date of Birth

LIST OTHER HOUSEHOLD MEMBERS ON REVERSE SIDE

I WANT MY MEMBERSHIP MATERIALS IN:

ENGLISH ☐

SPANISH ☐

I understand my membership is on an annual basis and all membership fees are non-refundable after 30 days.

I WANT TO PAY MY MONTHLY OR QUARTERLY MEMBERSHIP FEE BY:

BANK DRAFT: Please Draft on the ☐ 3rd or ☐ 18th of the month.

By submitting your enclosed check, you are authorizing the ongoing draft until AmeriPlan is notified of cancellation in writing.

X _____

SIGNATURE FOR BANK DRAFT

CREDIT CARD: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card # | Expiration Date

X _____

SIGNATURE FOR CREDIT CARD

A One-time $20.00 Registration Fee is required with each application.

First Month Membership Fee (Monthly Fee - $11.95 Single / $19.95 Family)	$ _____
First Quarter Membership Fee (Quarterly Fee - $35.85 Single / $59.85 Family)	$ _____
First Year Membership Fee (Annual Fee - $143.40 Single / $239.40 Family)	$ _____
One-time Registration Fee	$ 20.00
TOTAL AMOUNT DUE	$ _____

MONTHLY OR QUARTERLY PAYMENTS MUST BE MADE BY ELECTRONIC BANK DRAFT OR BY CREDIT CARD. INVOICING IS AVAILABLE FOR ANNUAL MEMBERSHIPS ONLY WITH FIRST YEAR PAID IN ADVANCE.

Enclose your check for payment and a voided check if paying monthly or quarterly by bank draft – 30-day written cancellation notice required.