Application and Registration

Patient Doctor Medical Plan
Association Member
921 CR3704B
Splendora, Texas 77372
Information: 866-373-8510
Fax: 832-543-8559

PRIMARY APPLICANT

Last Name			First Name			Middle Initial
Sex	Date of Birth (MM/DD/YY)		Identification Type SS__, DL__ or Passport__	ID Issued By		ID Number
Home Address			City		State	Zip
Mailing Address (if different than home address)			City		State	Zip
Primary Phone		Other Phone	Email address			

BENEFIT SELECTION

Plans 1- Basic 10 2-Concierge Plus 115,115,80 3-Concierge Elite 200,200,115
4 -Indemnity added 96,96,96 -max 288 5-Stop Loss added 54,54,54 6-Concierge Elite plus Ins plus payroll – EE $420 ES $766 EC $845 EF $1,248

Select the desired services for each member of your household:

Last Name ***(Same as Primary Applicant)***		First Name ***(Same as Primary Applicant)***		Service Plan (check) 1__2__3__4__5__6__	0-50K Indemnity. __ Over 50K Stop Loss __ HDC Amt______
Relationship to Primary ***(Same)***	Sex ***(Same)***	Date of Birth ***(Same)***	Are you Insured now? Yes__ No __ What Plan?______________________		Have a deductible? What amount? ______
Last Name		First Name		Service Plan (check) 1__2__3__4__5__6__	0-50K Indemnity. __ Over 50K Stop Loss __ HDC Amt______
Relationship to Primary	Sex	Date of Birth	Are you Insured now? Yes__ No __ What Plan?______________________		Have a deductible? What amount? ______
Last Name		First Name		Service Plan (check) 1__2__3__4__5__6__	0-50K Indemnity. __ Over 50K Stop Loss __ HDC Amt______
Relationship to Primary	Sex	Date of Birth	Are you Insured now? Yes__ No __ What Plan?______________________		Have a deductible? What amount? ______
Last Name		First Name		Service Plan (check) 1__2__3__4__5__6__	0-50K Indemnity. __ Over 50K Stop Loss __ HDC Amt______
Relationship to Primary	Sex	Date of Birth	Are you Insured now? Yes__ No __ What Plan?______________________		Have a deductible? What amount? ______
Last Name		First Name		Service Plan (check) 1__2__3__4__5__6__	0-50K Indemnity. __ Over 50K Stop Loss __ HDC Amt______
Relationship to Primary	Sex	Date of Birth	Are you Insured now? Yes__ No __ What Plan?______________________		Have a deductible? What amount? ______
Last Name		First Name		Service Plan (check) 1__2__3__4__5__6__	0-50K Indemnity. __ Over 50K Stop Loss __ HDC Amt______
Relationship to Primary	Sex	Date of Birth	Are you Insured now? Yes__ No __ What Plan?______________________		Have a deductible? What amount? ______

Senior Patient Association Membership and TBT Guest membership

The basic association membership includes Telemedicine from Teladoc, 24/7/365 and Doc Wellbee Discount Plans offered. It is paid annually by Debit, CC or Bank Draft. The first 6 months are free. I (we) agree to abide by the terms of the Senior Patient Association membership and the TBT Guest membership as printed in the Membership Booklets. *This application includes voting membership in Senior Patient Association and guest membership in TBT. As a consideration for the initial free membership in the Discount Medical Benefits Plan, I (we) give my (our) proxy to the manager of TBT to vote in any meeting held by Senior Patient Association or TBT.*

*Member's Signature: X*_____*Date*_____

Payroll Deduction Authorization (Frequency ☐ Monthly ☐ Bi-Weekly ☐ Weekly)

If paid by payroll deduction I (we) authorize the employer above to honor and pay these charges which may include the monthly payment plans as well as the annual membership fee. I (we) understand that in order to cancel these payments, I (we) must provide written notice to Patient Doctor Medical Plan and Group Employee Benefit Plan no less than 30 days before the next scheduled payment. Until such notice is received, I (we) agree that you shall be fully protected in honoring any such charge/draft.

Account Holder's Signature: X_____ Date: _____

Primary Care Services Agreement
I agree to a one-year contract with my selected Provider for access to primary care services. I understand any requests to change providers prior to the end of my 12-month contract must be submitted in writing to be reviewed and approved by Member Services.

Signature: X_____ _____ Date: _____

Imaging Services Agreement
I agree to a one-year contract with my selected Provider for access to imaging services. I understand any requests to change providers prior to the end of my 12-month contract must be submitted in writing to be reviewed and approved by Member Services.

Signature: X_____ _____ Date: _____

Lab Services Agreement
I agree to a one-year contract with my selected Provider for access to primary care services. I understand any requests to change providers prior to the end of my 12-month contract must be submitted in writing to be reviewed and approved by Member Services.

Signature: X_____ Date: _____

Specialty Group Care Services Agreement
I agree to a one-year contract with my selected Specialty Group Provider for access to primary care services. I understand any requests to change providers prior to the end of my 12-month contract must be submitted in writing to be reviewed and approved by Member Services.

Signature: X_____ Date: _____

Hospital Care Services Agreement
I agree to a one-year contract with my selected hospital for access to facility services. I understand any requests to change providers prior to the end of my 12-month contract must be submitted in writing to be reviewed and approved by Member Services.

Signature: X_____ Date: _____

If the plan is not paid by Payroll Deduction, then select the Method of Payment:

☐ **Bank Draft** ☐ **Debit** ☐ **Credit**

Terms and Agreement for Bank Authorization
I (we) authorize the financial institution named below to honor and pay these membership charges. This authority is to remain in effect until revoked by me (us) in writing, and until you actually receive such notice. I (we) agree that you shall be fully protected in honoring any such check/draft or credit/debit card charge. I (we) understand that in order to cancel this automatic deduction, I (we) must provide written notice to the Patient Doctor Medical Plan no less than 15 days before the next scheduled automatic deduction.

Bank Draft: Bank Name: _____ Bank Routing # _____ Account # _____

☐ **Credit** ☐ **Debit** ☐ **VISA** ☐ **MC** ☐ **Amex** ☐ **Discover**

Name on the card: _____ Card # _____ Exp. Date ___/___ CSV Code _____

Signature: X_____ Date: _____

I certify that I have given an outline of coverage for the policy applied for by this applicant.

Agent Name (Print): Don McCormick (DMFMO) Agent Name:_____
Agent Signature**: X Don McCormick** Agent #: 2328 Agent Tax ID_____