

# Mini Med Medical Enrollment Form for Member Benefits

**Administered by:**

**Marketing Partner: Care Alternative North America**

**Medical Management Group**

**Individual Enrollment Form**

**Fax Form to: 973-448-9946**

**Strategic Partner: TOWERS CARE ALTERNATIVE**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Street \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_ (MM/DD/YY)

Email address: \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_

**YES! I would like to enroll in the Mini Med Medical Healthcare Plan: Who Do You Want to Cover?**

**The Monthly Dues for the Health and Medical Benefits are as follows:**

<b>Mini Med Medical Healthcare Plan (Supplemental Hospital Indemnity Plan)</b>	
Self	<b>\$ 150.71</b> per month
Self + Your Child(ren)*	<b>\$ 204.71</b> per month
Self + Your Spouse*	<b>\$ 198.71</b> per month
Self + Your Spouse and Child(ren)*	<b>\$ 253.71</b> per month

**\*List all covered dependents' names and date of birth and SS# (any more please enter on separate sheet.)**

<i>Name</i>	<i>DOB</i>	<i>SS#</i>
SELF: _____		
SPOUSE _____		
CHILD 1. _____		
2. _____		
3. _____		

**Notice:** Any person who knowingly and with intent to injure, defraud or deceive CARE ALTERNATIVE NORTH AMERICA, who files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison. Any written or oral misrepresentation or warranty made in this application by the applicant or in the applicant's behalf, may, at the sole determination of CARE ALTERNATIVE NORTH AMERICA, be deemed material and defeat or void the CARE ALTERNATIVE NORTH AMERICA Certificate of Benefits and/or prevent its attaching.

**APPLICANTS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**MONTHLY PAYMENT OPTIONS**

**OPTION 1: CREDIT CARD...**

Credit Card Type: \_\_\_\_\_  
 Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp. \_\_\_\_\_ / \_\_\_\_\_

**OPTION 2: PAY BY CHECK/AUTOMATIC BANK DRAFT...**

AUTHORIZATION TO HONOR ACH DEBITS DRAWN BY CARE ALTERNATIVE NORTH AMERICA

As a convenience to me, I hereby request and authorize CARE ALTERNATIVE NORTH AMERICA, herein after called COMPANY, to initiate debit entries and/or collection entries to my account for charges drawn on my account by and payable to order of CARE ALTERNATIVE NORTH AMERICA, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the COMPANY's rights in respect to each such charge shall be the same as if it were a check drawn on COMPANY and signed personally by me. This authority is to remain in effect until CARE ALTERNATIVE NORTH AMERICA has received written notification from me of its termination in such time and in such manner as to afford CARE ALTERNATIVE NORTH AMERICA and DEPOSITORY reasonable opportunity to act upon it. I further agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, CARE ALTERNATIVE NORTH AMERICA shall be under no liability. I am aware and agree that this draft will be processed on or about the same time of the month as the original enrollment was drafted.

Name of Bank \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Routing No.: \_\_\_\_\_ Account. No.: \_\_\_\_\_

Authorized Signature of Bank Account Holder: \_\_\_\_\_ Date \_\_\_\_\_

**\*If paying by monthly bank draft please attached a voided check to this form**