



FAX TO:

866.523.1550

Discount Medical Plan Application

Date: ____ / ____ / ____

E-mail: _____

First Name: _____

Last Name: _____

Address: _____

City: _____ State ____ Zip _____

Daytime Phone: (____) _____

Evening Phone: (____) _____

ADDITIONAL MEMBERSHIP CARDS:

Send me _____ additional cards

First _____ Last _____

First _____ Last _____

First _____ Last _____

First _____ Last _____

Kit includes member and one dependent. \$1.00 charge for any additional dependents

SELECT YOUR METHOD OF PAYMENT

1. Bank Draft: I HEREBY AUTHORIZE New Benefits to initiate funds transfers from the depository financial institution account indicated below and authorize the depository financial institution to honor those transfers. Debit my payment of \$ 24.95 on the 20th of each month prior to my due date.

Name of Account Holder: _____ Account Type: Checking Saving
Name of Bank _____ City _____ State ____ Zip _____ Branch _____
Bank Routing # _____ ACCT # _____

2. VISA MASTERCARD DISCOVER AMEX Please charge my credit card: Annually Monthly

Name of Credit Cardholder _____
Acct # _____ Expiration date: ____ / ____ / ____

3. One Year Paid in Full: Total \$299.40 (\$299.40 for 12 months plus a one-time \$4.95 application fee).

Please make check or Money Order payable and mail to: New Benefits, 14240 Proton Road, Dallas, Texas, 75244.

ADDITIONAL TERMS AND CONDITIONS: To terminate or cancel the member agreement, please call (800) 800-7616 or send a written cancellation notice to New Benefits, 14240 Proton Road, Dallas, Texas, 75244. This agreement can be cancelled for non-payment.

SIGN HERE _____ Group #: DHS75034

only \$24.95/month

Plus a one-time \$4.95 application fee

Not available in KS, UT, WA, and VT

INCLUDES THE FOLLOWING BENEFITS:

Teladoc, Vision Care, Dental Care, Physician Visit/Hospital, Nurse hotline, Lifelock, Vitacost Vitamins, Emergency Travel Assist, Roadside Assist, Pet Care.