FLORIDA

UA PARTNERS DISCOUNT MEDICAL PLAN APPLICATION FORM

Use for customers with **Health, Medicare Supplement or Life Insurance** policies.

Disclosure: **This plan is NOT insurance.** The plan is optional. **The plan provides discounts at certain health care providers of medical services. The plan does not make payments directly to the providers of medical services. The plan member is obligated to pay for all health care services but will be entitled to receive a discount from those health care providers who have contracted with the discount medical plan organization.** The range of discounts for services offered will vary depending on the type of provider and service. Discounts on hospital services are not available in Maryland. This is not a Medicare prescription drug plan. This plan is administered by Coverdell & Company, Inc., a discount medical plan organization at 8420 W. Bryn Mawr, Suite 700, Chicago, IL 60631, 1-800-308-0374. **You have the right to cancel this plan within 30 days of the effective date for a full refund of fees paid.**

Last Name

Social Security Number ___ - __ - ____

Date (mm-dd-yyyy) __ - __ - ____

Resident State

☐ UA Partners

UA Partners payment mode will match payment mode of policy.

MONTHLY	QUARTERLY	SEMI-ANNUAL	ANNUAL
$6.95	**$20.85**	**$41.70**	**$83.40**

DISCOUNT MEDICAL SERVICES

Administered by Coverdell & Company, Inc.

- Vision
- Hearing
- Chiropractic
- Dental
- Prescription
- Vitamin & Nutritional Supplements
- 24-Hour Nurseline
- "Automatic" Claims Filing ® Plus *(Service available to Medicare Supplement primary cardholder only)*

*For information on current features, or to find currently participating locations, call **1-800-308-0374** or visit **www.FindBestBenefits.com** and use promo code **744402**.*

Available to customers without the purchase of an insurance policy.

MEMBER SIGNATURE REQUIRED

AGREEMENT: This plan is not insurance and my participation is optional. The plan features, including but not limited to discount percentages and any participating providers, are subject to change without notice. I agree to pay the plan fees in the mode set forth above, and I authorize the Company to collect the fees in the same manner (e.g., Direct Bill or Bank Draft) as the payment for my insurance policy. I have the right to receive a full refund of fees paid if my membership in the plan is canceled within 30 days of the effective date by me or by the Company. If I decide I no longer wish to participate in the plan, I will notify the Company or the plan administrator by telephone or in writing.

Signature

Member Initials