

**Membership Referral Program**

Complete and detach this form. Insert form in prepaid envelope and drop in the mail.

**AmeriPlan® Discount Program Membership Application**

PROVIDER # \_\_\_\_\_

**Primary Applicant's Information**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

SS# \_\_\_\_\_  Please register me (the primary member) automatically for SecureNet ID Monitoring.  
(Primary member's SS# required) or you may register later to activate ID Monitoring services.

Date of Birth of Applicant \_\_\_\_\_ Male/Female   Residence or Work Telephone \_\_\_\_\_ Alternate Telephone \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt.# \_\_\_\_\_

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

Email: \_\_\_\_\_  AmeriPlan® may send me updates regarding my account via email (email required)

**Members of Household - Additional names may be attached on a second sheet.**

First Name	Last Name	Date of Birth
_____	_____	____-____-____
_____	_____	____-____-____
_____	_____	____-____-____



Sweetheart Special Jan 25- Feb 25th  
 Half Off Dental Plus, Basic Wellness  
 and Total Health for One Year. 1/2  
 Off registration fee. Expires 2-25-10

A Discount Medical Plan Organization.

**AmeriPlan® Discount Programs are NOT INSURANCE.**

AmeriPlan® Corporation, 5700 Democracy Drive, Plano, Texas 75024 Fax: 469-229-4589

**I WANT TO PAY MY MONTHLY MEMBERSHIP FEE BY:**

**BANK DRAFT:** Enclose your check for payment AND a voided check if paying by bank draft.

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

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

**X** \_\_\_\_\_  
 SIGNATURE FOR CREDIT CARD OR BANK DRAFT

*By submitting your enclosed check or credit card information you are authorizing an ongoing monthly draft.*

**Cancellation Policy:** Cancellations require a 30-day written notice. Cancellation notifications may be sent by mail, fax or email at [stop@stopmembership.com](mailto:stop@stopmembership.com).

**Membership Selection**

**AccessSaver** ..... \$ \_\_\_\_\_  
 Monthly Fee: \$14.95

**SecureNet** ..... \$ \_\_\_\_\_  
 Monthly Fee: \$24.95

**Basic Wellness** ..... \$ \_\_\_\_\_  
 Monthly Fee: \$14.95

**Dental Plus** (check one) ..... \$ \_\_\_\_\_  
 **Individual** Monthly Fee: ~~\$14.95~~ \$7.48  
 **Household** Monthly Fee: ~~\$19.95~~ \$9.98

**Total Health** ..... \$ \_\_\_\_\_  
 Monthly Fee: ~~\$39.95~~ \$19.98

**ONE-TIME REGISTRATION FEE:** \$ \_\_\_\_\_  
 NON-REFUNDABLE

AccessSaver: \$5.00  
 \$20.00 SecureNet, Basic Wellness, Dental Plus: ~~\$20.00~~ \$10.00  
 Total Health: ~~\$30.00~~ \$15.00

**TOTAL AMOUNT DUE:** ..... \$ \_\_\_\_\_

\*SECURENET ID THEFT REIMBURSEMENT INSURANCE COVERAGE IS NOT AVAILABLE TO RESIDENTS OF NEW YORK AND MAY NOT BE AVAILABLE IN OTHER JURISDICTIONS. SECURENET ID THEFT PROTECTION IS LIMITED TO THE PRIMARY MEMBER. AMERIPLAN® SECURENET IS NOT AVAILABLE IN MONTANA OR VERMONT.

*If your application is processed between the 4th through the 18th of this month, your first draft will be on the 18th of next month, and each month thereafter.  
 If your application is processed between the 19th of this month through the 3rd of next month, your first draft will be on the 3rd of the following month, and each month thereafter.*

DETACH THIS STRIP FROM THE APPLICATION. INSERT THE COMPLETED FORM IN THE PREPAID ENVELOPE AND DROP IN THE MAIL. IF YOU DO NOT HAVE OUR PREPAID ENVELOPE, PLEASE MAIL THIS COMPLETED FORM TO:  
**AMERIPLAN®, 5700 DEMOCRACY DRIVE, PLANO, TEXAS 75024 ATTENTION: APPLICATION PROCESSING**