

## MEMBER ENROLLMENT FORM

COMPANY ID# \_\_\_\_\_

AGENT# \_\_\_\_\_

### PRIMARY MEMBER INFORMATION

TITLE:	FIRST NAME:	LAST NAME:	SUFFIX:
BIRTH DATE: ___/___/___ <small>(MM/DD/YYYY)</small>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
WORK PHONE:		HOME PHONE:	
ADDRESS:			APT:
CITY:	STATE:	ZIP:	

### DEPENDENT INFORMATION (IF APPLICABLE)

FIRST NAME:	LAST NAME:	SUFFIX:
BIRTH DATE: ___/___/___ <small>(MM/DD/YYYY)</small>	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT
FIRST NAME:	LAST NAME:	SUFFIX:
BIRTH DATE: ___/___/___ <small>(MM/DD/YYYY)</small>	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT
FIRST NAME:	LAST NAME:	SUFFIX:
BIRTH DATE: ___/___/___ <small>(MM/DD/YYYY)</small>	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT
FIRST NAME:	LAST NAME:	SUFFIX:
BIRTH DATE: ___/___/___ <small>(MM/DD/YYYY)</small>	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP: <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT

### BILLING INFORMATION

CREDIT CARD TYPE:	CARDHOLDER'S NAME:	CARD #
<input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER <input type="checkbox"/> AMEX	EXPIRATION DATE: ___/___ <small>(MM/YY)</small>	

By my signature below, I hereby authorize that I be charged as per the method indicated above for the one-time, nonrefundable fee of \$15.00 as well as the first month's fee of \$19.95. I further authorize that I continue to be charged \$19.95 on a monthly basis, on or about the same time every month for the applicable monthly fees until such time that I revoke that authorization by contacting the Sales Organization directly. I acknowledge that I have read and agree to be bound by the terms and conditions as provided in the membership agreement attached.

 \_\_\_\_\_  
 Applicant's Signature

 \_\_\_\_\_  
 Date

**Disclosure:** OptumHealth Allies is administered by HealthAllies®, Inc., a discount medical plan organization located at 505 N. Brand Blvd., Suite 850, Glendale, CA, 91203, 1-800-377-0263. **OptumHealth Allies is NOT insurance.** OptumHealth Allies provides discounts at certain health care providers for medical services. OptumHealth Allies does not make payments directly to the providers of medical services. The program member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.

**There is a 30-day period in which to cancel.** If you cancel within 30 days of enrollment (within 30 days of receipt of membership materials for residents of CO, IN, MO, MT, ND, OH, OK, SC, and SD), you will receive a full refund. (The application fee is not refundable except in AR, CO and TN.) Note to Utah residents: This contract is not protected by the Utah Life and Health Guaranty Association. The program and its administrators have no liability for providing or guaranteeing service or the quality of service rendered.