DISCOUNT MEDICAL PLAN MEMBERSHIP APPLICATION

Please fill out entire application and print clearly for your membership in our discount dental, vision, and prescription plan.

Applicant's Information

First Name _____ **Middle** _____ **Last Name** _____

Social Security Number _____ **Date of Birth** _____ **Male/Female** _____ **Contact Phone Number** _____ **Business Phone Number** _____

Complete Mailing Address or PO Box _____ **Apartment Number** _____

City _____ **State** _____ **Zip Code** _____ **Email Address** _____

Employer _____ **How did you hear about us?** _____

Please list only the household members you wish to enroll below

First, Middle and Last Name	Relationship	Male/ Female	Date of Birth

X_____ _____

Signature **Date**

Sales Consultant _____

Please see reverse side for prices, payment and payment options

This discount program is NOT a health insurance policy or a Medicare prescription drug plan and does not make payments directly to medical service providers. The program provides discounts at participating providers for medical services. Members are obligated to pay for all medical services, but may receive discounts on medical services from participating providers and the discount range will vary depending on provider type and medical services received. The program does not meet the minimum creditable coverage requirements under Massachusetts G.L. c. 111M and 956 CMR 5.00 and is not a Qualified Health Plan under the Affordable Care Act. The discount medical plan organization is Avia Dental Plan, Inc., 2001 Main Street, Suite 403, Wheeling, WV 26003, 1-888-431-2273, cancellations@aviadental.com, www.aviadental.com.

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Annual Membership Fees

Individual .....$ 109.00
Individual +1 .....$154.00
Family-enrolling 3 or more $169.00

For immediate coverage go to www.aviadental.com or fax or call our office with your credit card.

Plus $20.00 non-refundable processing fee per application ($20 includes all household members)

IF PAYING ANNUALLY:
Make check or money order payable to: **Avia Dental Plan®**
Mail payment and completed application to: **2001 Main Street, Suite 403, Wheeling, WV 26003**
Questions: **304-233-2253 Toll-free 1-888-431-2273 Fax 304-214-1257 For faster service sign up via web at *www.aviadental.com*.**

Credit card information: Please complete if using credit card for one-time payment or monthly option

[ ]Visa [ ] MasterCard [ ] American Express [ ] Discover

Card Number:**_____** ***Expiration Date:*****_____**

Cardholder's Signature**_____** ***Date*** **_____**

IF PAYING MONTHLY:
Monthly Bank and Credit Card Option

		Initial Payment	Monthly Auto Debit
Individual	**(enrolling 1 person)**	**$29.25**	**$ 9.25**
Individual +1	**(enrolling 2 people)**	**$33.25**	**$13.25**
Family	**(enrolling 3 or more)**	**$35.00**	**$15.00**

On monthly payment plan, the Initial Payment includes the $20 non-refundable processing fee and 1st month payment.

Monthly agreement for bank and credit card accounts

BANK DRAFT: Please draft my bank account on the [ ] 5th or [ ] 20th of the month or debit my credit card on the [ ] 15th of the month. I hereby authorize Avia Dental Plan® to initiate debit entries to my account as indicated on the voided check or credit card information enclosed until revoked by me in writing and the return of my member identification cards. This membership is effective for 12 months and will automatically renew for successive 12 month terms until cancelled. You may cancel at any time by writing to Avia Dental Plan, Inc.

_____ X_____ _____
Print Name **Signature** **Date**

Instructions for monthly payments
1. Complete Application 2. Circle how you are paying (annually or monthly and single, double or family) 3. Check date for automatic bank account or credit card debits 4. Print name, sign and date form 5. Include initial payment and voided check if paying from bank account

For residents of CO, FL, IN, LA, MD, MO, NH, NY, OH, TN, TX, UT, VT, and WV, if you cancel your membership within the first 30 days after the effective date of enrollment in the plan, you will receive a reimbursement of all periodic charges upon return of the discount card to Avia Dental Plan, Inc. This reimbursement will include the processing fee for residents of TN and VT. This contract is not protected by any state guaranty fund. The program and discount medical plan organization is not liable for providing or guaranteeing health services or for the quality of health services rendered. Membership and processing fees apply. This program is governed by the Membership Agreement provided upon the effective date. Participating providers are not available in all areas and are subject to change without notice. Program is not available in all states.