

# HealthFlex Limited Benefits Enrollment Application

**Yes!** I want to enroll in the HealthFlex Limited Benefits Plan selected below. I understand that once my membership starts, I (and eligible family members, if family program is selected) will be eligible to receive discounts on medical care, dental, vision, pharmacy, hearing and all additional features outlined in the HealthFlex Limited Benefits brochure.

**Primary Member:**

Name: \_\_\_\_\_ Gender: M or F Telephone: (\_\_\_\_) \_\_\_\_\_  
Last, First MI (circle one)

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email Address: \_\_\_\_\_

Dependents	First Name	Last Name (if different)	Birth Date	Gender
Spouse				M / F
Dependent Child				M / F
Dependent Child				M / F
Dependent Child				M / F
Dependent Child				M / F

## Program Options and Payment Information

**Select A Monthly Payment Method:**

**Credit Card:**  Visa  MasterCard  AMEX

\_\_\_\_\_/\_\_\_\_\_  
 Credit Card Number Expiration Date

Validation #: \_\_\_\_\_ (Three digit number located on the back of your card)

**Automatic Bank Draft** (Please attach a **VOIDED** Check)

\_\_\_\_\_  
 Routing Number Account Number

\_\_\_\_\_  
 Bank Name / City, State

**Billing Address if different from above:**

\_\_\_\_\_  
 \_\_\_\_\_

SILVER	Amount
Individual <input type="checkbox"/> \$129.95	
Family <input type="checkbox"/> \$219.95	
<b>One time enrollment fee</b>	\$100
<b>GRAND TOTAL</b>	
MONTHLY AMOUNT	

GOLD	Amount
Individual <input type="checkbox"/> \$159.95	
Family <input type="checkbox"/> \$279.95	
<b>One time enrollment fee</b>	\$100
<b>GRAND TOTAL</b>	
MONTHLY AMOUNT	

PLATINUM	Amount
Individual <input type="checkbox"/> \$199.95	
Family <input type="checkbox"/> \$369.95	
<b>One time enrollment fee</b>	\$100
<b>GRAND TOTAL</b>	
MONTHLY AMOUNT	

I authorize Amacore Group, NDHS's billing administrator, to deduct the periodic payments from my account as noted above for this membership. This authority shall remain in force until I notify Amacore Group or NDHS in writing of its cancellation.

**If you are not completely satisfied, within the first 30 days of your membership you may return your member ID cards to the address shown in your membership kit and receive a full refund of your membership fee. The one time enrollment fee is non-refundable, except in those states where refund provisions are specified by state law.**

**The HealthFlex Limited Benefits Plan includes the HealthFlex Medical Discount Program that is not health insurance.**

This plan provides discounts at certain healthcare providers for medical and ancillary services. This plan does not make payments directly to the providers of medical services. Members are required to pay the provider the discounted rate at the time of service. It is the members responsibility to confirm with Member Services that a provider is an active participant of the program prior to seeing that provider. Discount Medical Provider Organization: MedNet Benefits, Inc., 428 E. Thunderbird Road, #645, Phoenix, AZ 85022. Participating Providers are subject to change without notice and are not available in all areas. Actual savings may vary. A Member's participation in this program is governed by the terms of the Membership Agreement provided upon activation. Not available to residents of all states. Disputes shall be certified mailed to NDHS, LLC; 2187 Atlantic Street, Suite 905, Stamford, CT 06902. Not available to residents of FL, CT, KS, MS, MT, NJ, SD, SC, OK, OR or WA as of the date of this printing.

\_\_\_\_\_  
 Account Holder Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

(\_\_\_\_) \_\_\_\_\_  
 Phone# (if other than applicant)

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

**NDHS**  
 NDHS Representative #