



Fitness First Healthcare

Mail or Fax to:
Fitness First Healthcare
c/o Lifeguard Benefit Services
P.O. Box 93929
Southlake, TX 76092
or Fax: 817-416-5235

Applicant Information

Primary Member's Last Name: _____ First Name: _____ M.I.: _____ Sex: _____
 Date of Birth (MM-DD-YYYY): _____ Marital Stat.: _____ Social Security #: _____
 Address: _____ Apt. or Suite #: _____ City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Work Phone: _____ E-mail Address: _____
 Representative's Name: _____ Rep ID#: _____ Rep's Primary Phone: _____ Rep's Secondary Phone: _____

Dependent Information

Your membership includes your spouse, unmarried children & stepchildren under age 18 or under age 23 if a full time student.

Dependent's Name: _____ Date of Birth (MM-DD-YYYY): _____ Sex: _____ Relationship: _____
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 Dependent's Name: _____ Date of Birth (MM-DD-YYYY): _____ Sex: _____ Relationship: _____
 Dependent's Name: _____ Date of Birth (MM-DD-YYYY): _____ Sex: _____ Relationship: _____

Plan Selection & Monthly Fee

Select 5000 Plan
\$149.95 monthly / family

\$7,500 Accident Medical
\$50,000 Accidental Death
\$200 Weekly Disability Benefit
\$2,500 Critical Illness Benefit
\$4,000 Emergency Air Rescue
\$500 Dental Indemnity Benefit
\$0 Co-pay Vision Benefit
Physician & Hospital Repricing
Patient Advocacy Benefit
Individual & Family Counseling
Dental Discounts
Vision Discounts
Prescription Discounts
Canadian Rx Benefit
Chiropractic Care
Alternative Medicine
Hearing
24 Hour Nurse Hotline
Medifile & Diabetes Benefit
Diagnostic & Lab Test Discounts
Emergency Travel Assist
Vitamins & Nutritional Savings
Family Legal Benefit
Roadside Assistance

Select 4000 Plan
\$119.95 monthly / family

\$7,500 Accident Medical
\$50,000 Accidental Death
\$200 Weekly Disability Benefit
\$4,000 Emergency Air Rescue
\$0 Co-pay Vision Benefit
Physician & Hospital Repricing
Patient Advocacy Benefit
Individual & Family Counseling
Dental Discounts
Vision Discounts
Prescription Discounts
Canadian Rx Benefit
Chiropractic Care
Alternative Medicine
Hearing
24 Hour Nurse Hotline
Medifile & Diabetes Benefit
Diagnostic & Lab Test Discounts
Emergency Travel Assist
Vitamins & Nutritional Savings
Family Legal Benefit
Roadside Assistance

Select 3000 Plan
\$89.95 monthly / family

\$5,000 Accident Medical
\$30,000 Accidental Death
\$100 Weekly Disability Benefit
\$4,000 Emergency Air Rescue
\$0 Co-pay Vision Benefit
Physician & Hospital Repricing
Patient Advocacy Benefit
Individual & Family Counseling
Dental Discounts
Vision Discounts
Prescription Discounts
Canadian Rx Benefit
Chiropractic Care
Alternative Medicine
Hearing
24 Hour Nurse Hotline
Medifile & Diabetes Benefit
Diagnostic & Lab Test Discounts
Emergency Travel Assist
Vitamins & Nutritional Savings
Family Legal Benefit
Roadside Assistance

Select 2000 Plan
\$59.95 monthly / family

\$2,500 Accident Medical
\$20,000 Accidental Death
\$4,000 Emergency Air Rescue
Physician & Hospital Repricing
Patient Advocacy Benefit
Dental Discounts
Vision Discounts
Prescription Discounts
Canadian Rx Benefit
Chiropractic Care
Alternative Medicine
Hearing
24 Hour Nurse Hotline
Medifile & Diabetes Benefit
Diagnostic & Lab Test Discounts
Emergency Travel Assist
Vitamins & Nutritional Savings
Family Legal Benefit
Roadside Assistance

Select 1000 Plan
\$39.95 monthly / family

\$1,000 Accident Medical
\$12,000 Accidental Death
\$4,000 Emergency Air Rescue
Dental Discounts
Vision Discounts
Prescription Discounts
Canadian Rx Benefit
Chiropractic Care
Alternative Medicine
Hearing
24 Hour Nurse Hotline
Medifile & Diabetes Benefit
Diagnostic & Lab Test Discounts
Emergency Travel Assist
Vitamins & Nutritional Savings
Family Legal Benefit
Roadside Assistance

Rx Advoc. Plan
See pricing below

Family - \$34.95
 Single - \$19.95

Monthly Plan Fee \$ _____
 Rx Adv. Plan Fee \$ _____
 Registration Fee \$ 30.00
TOTAL DUE \$ _____

Payment Method

Monthly payments must be made by electronic bank draft (ACH) from a checking or savings account or from a credit card. Payments by check accepted only with annual payments.

Billing Address (if different from Applicant's address): _____ Apt. or Suite #: _____ City: _____ State: _____ Zip Code: _____

Bank Draft

Checking Savings (include a copy of deposit slip) Monthly Annually

Name on Account: _____ Account Holder's Signature: _____ Today's Date (MM-DD-YY): _____
 Initial Check #: _____ Bank Routing # (9 digits): _____ Account #: _____ Bank Name: _____

Credit Card

VISA MasterCard American Exp. Monthly Annually

Name on Credit Card / Debit Card: _____ Card Number: _____ Exp. Date (MM-YY): _____
 Card Holder's Signature: _____ Today's Date (MM-DD-YY): _____

All New Members Must Read, Initial & Sign

All Applicants must read and initial each of the 6 boxes below and then sign their name. This membership enrollment will not be accepted unless all are complete.

Applicant's Initials

- I understand that Fitness First Healthcare is NOT Major Medical Insurance. It is a health care savings and lifestyle benefits program that provides access to limited health insurance benefits as part of the Association membership. Certain insurance based products available through Fitness First Healthcare have restrictions, limitations and claim forms which may apply.
- Prior to enrolling as a member, I understand that it is my responsibility to evaluate the benefits of the Fitness First Healthcare membership program and determine if the benefits are appropriate to meet my specific needs and expectations. I also understand that it is my responsibility to utilize the proper protocol for accessing healthcare services as described in my membership materials. I understand that certain benefits utilize specific provider networks and that Fitness First Healthcare cannot guarantee the participation of any provider, even if they are identified as a network participant. If applicable to my chosen plan, it is my responsibility to confirm the availability of participating network providers in my area necessary to meet my needs and expectations and to confirm the participation of any specific providers which are important to me. I understand that participating providers and networks are subject to change without notice.
- I understand that Fitness First Healthcare will process my enrollment and initial payment immediately. I understand that if my enrollment is processed between the 1st and 14th of the month, my effective (start) date will be the 15th of the same month or if my enrollment is processed between the 15th and the last day of the month, my effective date will be the 1st of the following month. I also understand that my member materials should arrive within 7 - 10 business days after my effective date, if not before.
- I understand that each month my membership payment is due sixteen (16) days in advance of my monthly membership period. As such, I also understand it is possible that my first monthly recurring draft/charge could take place as early as two (2) weeks after my initial payment, depending on what day of the month my membership enrollment is initially processed. I understand that it is my responsibility to ensure that funds are available in my account for the cost of my membership. I also understand that there is a minimum charge of \$25 which may be billed to me if Fitness First Healthcare receives notice of any form of payment denial. I understand that Fitness First Healthcare is not required to notify me if my payment should be declined and that failure to pay all applicable fees by the end of the billing period will result in the cancellation of my membership.
- I understand that neither Fitness First Healthcare, Fitness First Healthcare Independent Representatives, nor the networks accessed are responsible for the outcome of the medical care or lifestyle benefits received, the ultimate cost of that care or benefit, or if a provider(s) elects not to participate. I understand that the savings through the discount benefits can vary and that no guarantee of any specific savings can be given. As such, I agree to hold all parties harmless and I assume total responsibility for all my costs, including that of my Fitness First Healthcare membership without regard to reimbursement of my membership fees paid.
- I understand that I must give Fitness First Healthcare written notice of intent to cancel my membership in order to terminate my enrollment and cease future charges. In accordance with this policy, any membership payments which are scheduled to occur within 10 days following Fitness First Healthcare's receipt of my cancellation notice will remain in effect, but will cease thereafter. I also understand and agree that the registration fee is non-refundable, but I am eligible to receive a refund of my monthly membership fee if I provide Fitness First Healthcare with a written notice of cancellation within 30 days after signing this member enrollment form.

I understand that Fitness First Healthcare is NOT Major Medical Insurance.

I authorize Fitness First Healthcare to debit my designated financial account for the initial cost of the selected membership plan and associated fees as well as for the monthly cost of my membership in accordance with my chosen payment schedule. Or, if I am an employee under a company enrollment, I authorize my employer to deduct this amount from my check each month. Furthermore, I understand and agree to abide by Fitness First Healthcare's Member Terms & Conditions and by the policies and provisions listed above as indicated by my initials of acceptance.

Applicant's Signature: X **Today's Date:** / /

Beneficiary

Designated Beneficiary for the Accidental Death Benefit (if applicable)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Beneficiary's Name	Relationship to Primary Member	Beneficiary's Phone #			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Beneficiary's Address	Apt. or Suite #	City	State	Zip Code	

Proxy Statement

CASA Association

(Applicant's Signature required)

I hereby designate and appoint the Secretary of the Association in office at any particular time and from time to time as my proxy and my agent and attorney-in-fact to receive all notices of meetings of the members of the Association, to attend and vote on my behalf at any and all meetings of the members of the Association, to execute consents and to otherwise act for me in the same manner and with the same effect as if I were personally present. I authorize my proxy to substitute any other person to act under this proxy, to revoke and substitute and to file this proxy and any substitution or revocation with the Association. I understand that this proxy is a voluntary designated appointment and that I have a right to receive all notices of meetings of members and to attend such meetings and vote thereat. In such event, I will notify the Secretary of the Association of my desires in this respect.

Applicant's Signature: X **Today's Date:** / /

Representative Guarantee of Accuracy

The enrolling representative must read and sign the statment below in order for this membership enrollment form to be accepted.

I, the enrolling Representative, do hereby attest that I have accurately explained the benefits of the Fitness First Healthcare program to the Applicant, answering all questions and concerns to the best of my ability. As such, I agree that I have evaluated the benefit needs of the Applicant and advised him/her accordingly based on my interpretation of the Applicant's best interests. Finally, I acknowledge that this Member Enrollment Form has been completed both legibly and in its entirety, that I will submit this information online through the Fitness First Healthcare enrollment center and that immediately thereafter I will fax or mail a copy of this enrollment to the Fitness First Healthcare Enrollment Center noted on the front of this application.

Representative's Signature: X **Today's Date:** / /

For Office Use Only

<input type="text"/>	<input type="text"/>
Member Name	Member Admin. ID#