GROUP APPLICATION FORM

Group	Today's Date (mm/dd/yyyy)

City	State	Group Contact Phone Number	Enroller Name/ID #

PAY FREQUENCY *(check appropriate box)*

Please choose a package. (Pick one product only)

☐ Weekly (52 times a year) ☐ Bi-Weekly (26 times a year) ☐ Semi-Monthly (24 times a year) ☐ Monthly (12 times a year)

Membership Cost Per Person	Weekly	Bi-Weekly	Semi-Monthly	Monthly
☐ Basic Membership	**$4.60**	**$9.20**	**$9.97**	**$19.95**
☐ Ultimate Membership	**$11.51**	**$23.03**	**$24.95**	**$49.90**
☐ VIP Membership	**$23.05**	**$46.10**	**$49.95**	**$99.90**

COVERED MEMBERS

Name *(please list First, Middle, and Last) Attach Employee roster form for additional names.*	**Amount**
Group Member	
Additional Member	
Additional Member	
Additional Member	
Additional Member	
Total Amount	

Home Address	Phone Number

City	State	Email Address	Group Member Social Security #

AUTHORIZATION

I represent that the above information is correct to the best of my knowledge and agree that the above statements are true and complete. I fully understand that any significant mis-statements or ommissions in completing this enrollment from may delay processing my enrollment request and/or result in the denial of membership benefits.

I authorize the required collection of dues by the Group for my elected membership(and the membership of additional members, if any). I reserve the right to revoke this collection at any time with written notifications to said Group. I hearby authorize the Group to collect the amount shown above as consideration for contract issued by Call MD Plus, Inc., Tampa, Florida during the continuance of my membership by this Group or until the authorization is revoked by written notice to said Group.

Responsability for Payment: You are primarily responsible for your membership dues payments, and if your Group fails to make payment on your behalf, you must make the payments directly to Call MD Plus, Inc.

Membership services will begin upon receipt of membership card: Please return this form to your group or authorized Call MD Plus, Inc. Sales Associate.

Signature of Group Member *(required)*	Date Signed
Sales Associate Signed	Date Signed

THIS IS NOT INSURANCE