EMPLOYER ACCEPTANCE LETTER

5000 Legacy Drive Suite 300 • Plano, Texas 75024
(469) 229-4500

ENROLLER NAME _____ **ENROLLER #**_____

Thank you for providing AmeriPlan® benefits to your employees. As members of AmeriPlan,® you employees and their households will enjoy reduced cost for their healthcare needs.
You will recieve your Group's monthly invoice on or about the 10th of each month or you may access your account through the Group Portal.

Name of Company or Firm: _____

Company Contact: _____

Mailing Address (Must be street address. No P.O. Boxes.): _____

City: _____ **State:** _____ **Zip:** _____ **Telephone: ( )** _____

Effective Date: _____ **E-Mail Address:** _____

Number of Applications:_____ **Amount Enclosed with Application: $**_____

By: _____ **Date:** _____
Signature & Title

AmeriPlan® are NOT insurance

❑ **Dental Plus** – includes, Dental, Vision, Prescription and TeleHealth discounts.

❑ **Deluxe Plus** – includes all discount programs

❑ **TeleHealth Plus** – includes, TeleHealth, Prescription and In office doctor visit discount programs

I, the undersigned employer, do hereby state that a full and complete explanation of the discounted fees and Plans have been given to me, and that I fully accept and subscribe to all the terms and conditions contained in this letter. We assume no responsibility to AmeriPlan® after the termination of any employee. It is further agreed that AmeriPlan® may, upon notice to me and to my employees, discontinue AmeriPlan® benefits as a whole. I acknowledge that as the employer, it is my duty to explain the Plan(s), the discounted fees and the services to my employees, and that any employee may voluntarily discontinue participation in the Plan by providing written notice to AmeriPlan®, 5000 Legacy Drive Suite 300, Plano, Texas 75248, Attn: Group Benefits Dept.

Payment options

❑ Company Monthly List Bill
(Each month AmeriPlan® will send an invoice listing all employees and fees to be paid.)

❑ Company Bank Draft / CREDIT CARD
(Company agrees to pay for employee's monthly membership fees by either Bank Draft or Credit Card.)

YOU MUST ENCLOSE A VOIDED PRE-PRINTED COMPANY CHECK IF USING BANK DRAFT

BANK DRAFT AUTHORIZATION

I hereby request and authorize _____ (Depository Bank) to pay drafts in such amounts as may now or hereafter be payable to AmeriPlan® provided there are sufficient funds in said account to same upon request. This authority shall remain in full force and effect until AmeriPlan® and/or Depository (bank) have received written notification from me of its termination in such a manner and time as to afford AmeriPlan® and/or Depository (bank) a reasonable opportunity to act on it. I agree to notify AmeriPlan® of any changes to my savings/checking account number or bank. I agree that AmeriPlan® shall have no liability whatsoever except to the extent created by my payment.

By: _____ Date: _____
Authorized Signature and Title

PAYMENT PROCESSING WILL BE ADMINISTERED BY AMERIPLAN®

CREDIT CARD: ❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

Card #:_____ Expiration Date: _____/_____

Signature of Cardholder:_____