INDIVIDUAL APPLICATION - GROUP

USE THIS APPLICATION FOR GROUP MEMBERSHIPS
SEND WITH COMPLETED EMPLOYER ACCEPT LETTER

For Office Use Only

ENROLLER NAME: _____ **ENROLLER #:**_____

Company Name: _____

Employee: _____ Home Phone: ( )_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S Date of Birth: _____

Email:_____

❑ **Dental Plus** ❑ **Deluxe Plus** ❑ **TeleHealth Plus**

Spouse: _____ ❑ M ❑ F

Last First D.O.B.

Please list eligible household members. Attach additional sheets if necessary.

Household Member Last Name	First	D.O.B.	Male	Female

AmeriPlan® is NOT insurance

PLEASE CAREFULLY READ THE INFORMATION BELOW AND SIGN

1. I hereby apply for membership in Healthcare Cost Reduction Plans™ for myself and eligible household members listed, and authorize my employer/organization to make deductions, if any, required as my contribution for the membership fee.

2. I agree, for myself and any eligible household members listed, to abide by the rules and regulations of HCCRP

3. I represent that the information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I will promptly advise HCCRP and my employer of any changes in this information.

Signature: _____ Date: _____