FIVEPOINTS
HEALTH BENEFIT PLANS

TELEMEDICINE 2020 ENROLLMENT FORM

NAME: _____
(LAST) (FIRST) (MIDDLE)

DOB:_____ **EMAIL:**_____ **PHONE**:_____

SOCIAL SECURITY/SOCIAL ID #: _____ **GENDER:** [ ]M [ ]F

ADDRESS: _____
(NUMBER/STREET) (APT#) (CITY,STATE) (ZIP)

PLAN SELECTION (Please select plan option)

- ☐ **Telemedicine-BASIC Plan** (Unlimited Visits, Zero Cost, with **NO** Co-Pay)
  - OPTUMRX-PHARMACY PLAN **IS** INCLUDED
- ☐ **Individual:** $18.95/month
- ☐ **Individual & up to 3 Dependents:** $28.95/month
- ☐ **Family, Spouse, & up to 3 Dependents:** $35.95/month

FAMILY MEMBER INFORMATION

LAST NAME	FIRST NAME	M.I.	D.O.B	GENDER	RELATION TO APPLICANT
				(M/F)	
				(M/F)	
				(M/F)	
				(M/F)	

PAYMENT INFORMATION

- ☐ **BANK DRAFT**

Name of Bank: _____ Name on Account: _____

Account Number: _____ Routing Number: _____

☐ Please bill my card for my monthly premium shown above and include the appropriate processing fee (Please check)

CREDIT CARD AUTHORIZATION:

[ ] Mastercard [ ] Discover [ ] American Express [ ] Visa

Cardholder Name:_____

Card Number:_____ Expiration Date: (/) CVS: _____