



Discount Medical Plan Application

First Name _____ Initial _____ Last Name _____

Address _____
Number, Street City State Zip Code

Home Phone Number _____ Work Phone Number _____

Cell Phone Number _____ Date of Birth _____ Sex _____
mm/dd/yyyy

Other members of your household to be registered if selecting the Prescription Savings Plan:

Name	Sex	Date of Birth	Relationship	Name	Sex	Date of Birth	Relationship
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Select Desired Plan(s) : Administered by Coverdell & Company, Inc., a discount medical plan organization, 8420 W. Bryn Mawr, Ste. 700, Chicago, IL 60631.

Member Only

- Discount Medical Plan Card \$ 16.95 per month
- Prescription Savings Plan \$ 14.95 per month

Discount Medical Plan Card Benefits

- Physician services - 5 to 40% savings
- Lab work services 15 to 70% savings
- Hospital - 5 to 40% savings
- Prescription drugs - 20% average savings
- Dental services - 10 to 50% savings
- Vision services - 10 to 60% savings
- Chiropractic care - 20 to 40% savings
- Hearing aids and supplies - 10 to 20% savings
- Vitamins & nutritional supplements - 25 to 50% savings
- PDC provides patient medical advocacy services to plan members at no extra charge

Member and Family

- Discount Medical Plan Card \$ 19.95 per month
- Prescription Savings Plan \$ 19.95 per month

Prescription Savings Plan Benefits

- Preferred generic prescriptions at \$10 or less
- Preferred brand-name and generic Rx at \$20 or less
- 20% average discount for non-preferred Rx

Payment Method

Credit Card

- Visa MasterCard Name on Card _____
- Discover American Express Credit Card Number _____
- Expiration Date _____ Security Code _____

EFT

This option is an Electronic Funds Transfer (EFT) from your bank account on a monthly basis. You must attach a voided check for this option.

I hereby authorize the Best Benefits Plan and Patient Directed Care to bill my credit card or charge my bank account for the discount plan(s) of my choosing. This authorization is to remain in full force until cancelled by me according to the cancellation provisions. I have 30 days to cancel the discount plan to receive a full refund.

Signature

Date

Mail or Fax this application to:

Patient Directed Care ✧ 15511 N. Florida Ave., Ste D ✧ Tampa, FL 33613 ✧ Fax (813) 908-8896 ✧ Phone (813) 968-7007



Disclosure: This plan is NOT insurance. The plan provides discounts at certain health care providers for medical services. The plan does not make payments directly to the providers of medical services. The plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount medical plan organization. The range of discounts for services offered will vary depending on the type of provider and service. Discounts on hospital services are not available in Maryland. This is not a Medicare prescription drug plan. This plan is administered by Coverdell & Company, Inc., a discount medical plan organization at 8770 W. Bryn Mawr, Suite 1000, Chicago, IL 60631, 1-800-308-0374. have the right to cancel this plan within 30 days of the effective date for a full refund of fees paid. This Plan is not available in the state of Vermont and Massachusetts.