APPLICATION

Medical Discount Plan Membership

Applicant's Name / Commercial Group	Address	Phone Number	E-mail	Tax ID Number

Members

Member's Address	Apt #	City	State	Zip	Primary Doctor

Home Phone No.	Work Phone No.		E-mail

Main Subscriber Name	Last Name	Relationship	Date of Birth	Sex	Social Security	Primary Doctor
Dependant 1						
Dependant 2						
Dependant 3						

It is necessary to show the Member's ID card and you must not have any balance due at the time of service.

Method of Payment

☐ Credit Card ☐ Automatic Debit ☐ Check or Money Order

Payment amount $ _____

Mode of Payment

☐ Monthly (1 month) ☐ Annual (12 months / 13th month free) ☐ Other _____

Discount: $ (_____)

Member Fee

Administration Fee: $ 28.oo
(One time fee)

☐ 1 Person $ 30.oo ☐ 2 Persons $ 50.oo ☐ Family $ 80.oo

Total : $ _____

Credit Card Authorization

☐ Visa ☐ MasterCard ☐ Other

Credit Card Number

Expiration Date

Month: _____ Year: _____

I Authorize CSMC to debit from my account the amount corresponding to my monthly fee.

Signature _____ Date _____ Amount $ _____

Automatic Debit Authorization I authorize CSMC ProSalud Plan to electronically debit from my account the cost of my affiliation. The name of my bank, identification number of the bank and my account number are written down at the end of this application form. Besides, I enclosed a void check as proof of my account and the corresponding numbers. I authorize my bank to debit from my account in favor to CSMC Prosalud Plan and pay the monthly fee approved below and signed by me. I understand that the treatment of this automatic debit will be the same that the one corresponding to the checksas signed for me. I understand that in case the debit not be applied with or without any just justification, the bank is free of any responsibility. CSMC has been authorized to send this authorization to the bank that is mentioned below. Copy of this authorization with my signature on it will be accepted as original authorization. This authorization will be effective until that moment that Colony Springs Medical Center receives my written notification requesting the termination of my affiliation, this notification will be sent with reasonable time to allow Colony Springs Medical Center to act on it. I also understand that if my account does not have the necessary funds or if the debit cannot be done for any omission of my behalf I will be charged $ 25.oo.

Name of the Bank

Account Number

Route Number

Membership Fee $ Signature

I authorize the employees of CSMC to see my diagnosis and to intervene in the coordination of medical services for me and my dependants. I accept all the terms and conditions written on the back of this application.

Signature of the Applicant	Application Date	Name of Sales Representative	Signature of Sales Representative:	Number:

Effective Date	Application processed by	Signature

CSMC PROSALUD PLAN ***(954) 718 3393***
Organization Discount Medical Plan
8333 W. Mc Nab Rd. #116, Tamarac, Fl. 33321

White / CSMC ProSalud Plan *Pink / Member* *Yellow / Sales Rep*

CSMCPSP-01-01 eng.

Prosalud Plan Gold Plan (Medical Discount Plan)

Disclaimer

This plan is not a health insurance policy. This plan provides discounts with certain medical services providers. This plan does not make payments directly to the providers of medical services. Plan members are obligated to pay for all healthcare services, but will receive a discount from those health care providers who have contract with CSMC Prosalud Plan.

Benefits

The benefits of this discount medical plan are contemplated in the brochure CSMCPSP-01-04 attached and is part of this contract.

Terms and Conditions

Your welcome package and membership card should arrive by mail within approximately 10 business days from the day your application is processed. If at any time you have any questions, please contact your CSMC Prosalud plan representatives or call CSMC Prosalud Plan at (954)718-3393.

This agreement is between you (Primary Subscriber) and CSMC Prosalud Plan and sets out the terms and conditions of CSMC Prosalud Plan . This agreement shall be affective on the 15th day of the month (if the application was processed before the 10th the month) and the last day of the month (if the application was processed before the 25th of the month).

It is the responsibility of the Primary Subscriber to call CSMC Prosalud Plan Customer service department to locate the participating providers if needed. The list of providers is subject to change at any time without further notice to Primary Subscriber. CSMC Prosalud Plan does not guarantee or warrant the quality or accessibility of services or benefits delivered by the respective providers. The Primary Subscriber is also responsible for payment to providers for medical services provided as well as related expenses. Savings are based on pre-negotiated rates, and those rates may change from time to time. All fees listed or quoted by CSMC Prosalud Plan are subject to change at any time without notice.

Family Nucleus

Family nucleus Means: A married couple and their children under the age of 18, maximum 4 persons. The main subscriber needs to provide proof of relationship if within the family nucleus any of the children have a different last name. Inclusion: If the main subscriber needs to add a family member to this application for CSMC Prosalud Plan a new application needs to be done indicating that it is an inclusion to his family nucleus. In this case CSMC Prosalud Plan will charge only the difference of the monthly fee for the following months, per family, and the processing fee ($28.oo) one time only. The same procedure will be done if the main subscriber needs to remove members from this application.

Method of Payment, renewals and termination

The term of the membership is a month-to-month basis. The member will be charged monthly according to his due date. It will be terminated automatically if a monthly payment is not made during the following five days. A member can be reinstated if the past due balance is paid in full during he first two months from the date of the cancellation, and the member has the right to cancel the membership by sending a written notification 30 days prior to the termination date.

Members paying by bank draft or credit card will have their account charged monthly. Any items returned by the bank including bank draft, checks or credit card charges will cause a returned item fee of $25.oo at this point the membership be placed on hold until the member pays their balance in full, at that time the patient will be reinstated with the plan.

Complaint procedure

Every patient is entitled to file a complaint by contacting CSMC Prosalud Plan at (954)718-3393 or by filing a written complaint to 8333 W Mc Nab Rd #116, Tamarac, Fl 33321. All complaints involving quality of medical care must be addressed to the medical doctor with a copy to CSMC Prosalud Plan (Managing Director). CSMC Prosalud plan only offers discounts on medical services rendered by certain contracted providers, CSMC Prosalud Plan will not interfere in such medical care, CSMC Prosalud Plan is not responsible for the quality of services given by the contracted providers. CSMC Prosalud Plan will provide an answer to the complaint within 30 days from the day the complaint was received.

Cancellation

Members are financially responsible for all membership monthly charges and any related costs of collections, unless a cancellation request has been received by CSMC Prosalud plan at least 15 days prior to the set up date for the monthly charge. Member may cancel their membership sending a letter 30 days prior to the date of termination to our main office: 8333 W. Mc Nab Rd #116, Tamarac, Fl 33321.

If the plan is cancel within the first 30 days and the member has not used the membership, they will receive a full refund of the fee (processing fee is not reimbursable).

White/CSMC Prosalud Plan Pink/ Member Yellow/ Sales Representative