SPONSOR* INFORMATION

Name: _____

Phone: _____

IMA#: _____

FamilyCare
discover the advantage

Association Heath Care Management, Inc. d/b/a Family Care is the discount medical plan organization.

11111 Richmond Ave., Suite 200, Houston, Texas 77082
Phone: 800.323.4057 Fax: 713.400.0099

FAMILY CARE ADVANTAGE PLAN APPLICATION

THIS PROGRAM IS NOT INSURANCE NOR INTENDED TO REPLACE INSURANCE

FOR OFFICE USE ONLY

FN: _____

CATG: _____ IMA#: _____

COMM: _____

CARD HOLDER INFORMATION *(PLEASE PRINT CLEARLY)*

Date: ___/___/_____ DOB: ____/____/_____

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: ____-____-_____ **SELECT A LANGUAGE** ☐ ENGLISH ☐ SPANISH ☐ KOREAN

Email: _____

(By including email address, the member consents to receiving updates/changes in discount program and/or discounted rates by email.)

HOUSEHOLD INFORMATION *(TO ADD MORE MEMBERS, USE A SEPARATE SHEET OF PAPER.)*

Spouse's First Name: _____ Last Name: _____ DOB: ___/___/____

Household Member: _____ Household Member: _____

DOB: ___/___/_____ DOB: ___/___/_____

Household Member: _____ Household Member: _____

DOB: ___/___/_____ DOB: ___/___/_____

PACKAGE

FAMILY CARE ADVANTAGE PLAN

$49.95 per month
$50.00 one-time application fee

HEALTHCARE SERVICES

1. **Professional Services**
   - Dental Care
   - Pharmacy Discount Program
   - $20 Generic Prescription Card
2. **Diagnostic Services**
   - Comprehensive Blood Tests
   - Lab Services
   - Radiology & Imaging

BILLING INFORMATION *(PLEASE CHOOSE ONLY ONE METHOD OF PAYMENT)*

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ **Bank Draft or Debit** *(please choose one)* **Checking** **Savings**

Name of Account Holder_____

Bank Name: _____ Bank Transit #: __ __ __ __ __ __ __ __ __ Account #: _____

☐ **Credit Card** ☐ VISA ☐ MC ☐ DISCOVER ☐ AMERICAN EXPRESS Account #: __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

Name as it appears on Credit Card_____

Expiration Date: ____/_____ CVV2 #: __ __ __ __ *(the last 3 digits on the signature line of your credit card, 4 digits on American Express)*

I authorize Family Care, or its designated attorney-in-fact to electronically draft my account or bill my credit card indicated above for my one-time initial payment, and my membership recurring dues. I understand that I am eligible for a refund of my membership dues if I cancel in writing by fax or mail within forty-five (45) days from postmark on my new packet. $30 will be held as a non-refundable processing fee.

☐ ***Check this box if you are paying for this Membership and are not the member.***

X_____
Signature of the Depositor or Credit Card Holder. *(Must be signed by employer if employer is paying the membership dues.)*

☐ **Invoice** *(Invoice billing is done on the 10th of the month. Payment is due on the 1st of the following month. Monthly invoice not available.)*
☐ **Quarterly** *(Initial Payment must cover 3 months.)* ☐ **Semi-Annually** *(Initial Payment must cover 6 months.)* ☐ **Annually** *(Initial Payment must cover 1 year.)*

I understand that Family Care is NOT insurance. _____ *(Initial)*
I am applying to become a Family Care Member.

X_____ ***Date:*** _____
Signature of the Applicant

For a complete description of the Plan's benefits and terms and conditions, please see the Member Information Guide.

* The Sponsor is the person who marketed this plan to the member.

One-time Application Fee:	
Membership Dues: *(dues x number of months selected)*	
TOTAL:	

NOTE: Family Care membership does not satisfy the federal mandate for individuals to obtain health coverage that includes essential health benefits and that fully complies with the Affordable Care Act.

SAMPLE DENTAL COMPARISON CHART FOR CALIFORNIA REGION 2*

Dental Procedure	Usual Fee**	You Pay	Savings	% Savings †
Preventive Care				
Adult Cleaning	$102.00	$67.00	$35.00	34.3%
Full Mouth X-Rays	$149.00	$68.00	$81.00	54.4%
Comprehensive Exam	$97.00	$36.00	$61.00	62.9%
Other Common Dental Procedures				
White Filling (1 Surface)	$156.00	$65.00	$91.00	58.3%
Crown (Porcelain/Noble Metal)	$1,114.00	$727.00	$387.00	34.7%
Partial Denture (Removable)	$1,317.00	$447.00	$870.00	66.0%
Root Canal (Front Tooth)	$719.00	$455.00	$264.00	36.7%
Extraction (Impacted Wisdom Tooth)	$559.00	$332.00	$277.00	40.6%
Dental Implant (Not Including Crown)	$2,606.00	$1,545.00	$1,061.00	40.7%
Orthodontics & Teeth Whitening				
Full Orthodontic Case (Braces)	$5,000.00***	$3,973.00	$1,027.00	20.5%
Professional Teeth Whitening (At Home Trays)	$734.00	$294.00	$440.00	59.9%

PROGRAM DISCLOSURES

Discounted Prices specific to your procedure and location can be obtained via the website, ***www.FamilyCareCard.com***. For a printed list of the discounted prices, call Member Services at ***1.800.323.4057***.

* Region 2 includes: Imperial, Riverside, San Bernardino, and San Diego Counties.

** Usual fee is an average based on the 80th percentile of the 2010 "Medicode" fee schedule, a national fee profiling service. Members may review pertinent fee information by contacting Member Services at ***1.800.323.4057***. Fees may vary slightly by geographic region.

***Fee determined by First Dental Health claims review data. Actual savings may vary by dental office.

† See sample of dental savings above.

1 This service goes into effect thirty (30) days after enrollment. For a more complete disclaimer go to ***www.servicemyplan.com*** and click on the "Comprehensive Blood Tests" link, and then "Disclaimer" link. The first of the two free CWP blood labworks, for the primary member or spouse, one each per year, goes into effect in ninety (90) days after enrollment. The second free CWP blood labwork can only be ordered/taken by the other person, and is effective in one-hundred and eighty (180) days after enrollment.

2 The $20 Generic Prescription Card goes into effect forty-five (45) days after enrollment.

DISCOUNT SERVICES DISCLOSURES

DISCLOSURES:

a. Family Care Advantage is a membership plan that one must join in order to obtain the advertised discounts.
b. An initial and a monthly fee are required from the prospective member to join The Family Care Advantage Plan.
c. Plan members obtain the advertised discounts only from the providers contracted with the plan.
d. Plan members may be required to pay for all healthcare services at the time they are rendered in order to receive the discount.
e. Members and prospective members can obtain plan information, enrollment, terms and conditions and pricing information by calling ***1.800.323.4057*** or via web at ***www.FamilyCareCard.com***, or by contacting their sales representative.

GRIEVANCE POLICY INFORMATION

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1.800.853.9594 (TDD: 713.414.4988; Toll free TDD: 866.545.1155) and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review. If you are eligible for Independent Medical Review, the Independent Medical Review process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1.888.HMO.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The Department's Internet Web site *http://www.hmohelp.ca.gov* has complaint forms, Independent Medical Review application forms and instructions online.

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