CAREINGTON 500 SERIES DENTAL – EYEMED VISION – PROGRAM APPLICATION

Yes! Please start my dental and vision program immediately. I understand I'll have 45 days to use my plan absolutely risk free.
Mail applications to Long Term Consumer Care, Inc., N27 W23960 Paul Road, Suite 201, Pewaukee, WI 53072.
To join by phone, call (800) 544-9505 or by Fax (262) 523-1910. You may also Join online at www.ConsumerBenefits.net.

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY, STATE, ZIP	WORK PHONE
HOME PHONE	SOCIAL SECURITY #	DATE OF BIRTH
SPOUSE'S NAME (**IF INCLUDED**)	DATE OF BIRTH	
CHILDREN'S NAMES (**IF INCLUDED**) 1. 2. 3.	DATE OF BIRTH	**E-MAIL ADDRESS**

Please circle the desired coverage level:

Member Only	$8.95 monthly + One Time $10.00 Application Fee.	$89.95 annually + One Time $10.00 Application Fee.
Member Plus Family	$11.95 monthly + One Time $10.00 Application Fee.	$109.95 annually + One Time $10.00 Application Fee.
Effective Date – **Circle One:** *First of this month* or *First of Next Month*		

Choose One:

A. ☐ **Bill my credit card.**

☐ Visa ☐ American Express ☐ Mastercard ☐ Discover

Account #____________________________ Expiration Date________________ Name on card______________________

B. ☐ **Bill my checking account.**

Bank/institution name:____

Name of account holder:____

Routing number:_______________ Account number:_____________________

Please remember to enclose a check for the appropriate amount. Checks payable to CAREINGTON.

C. ☐ **Use the enclosed check as payment.** ***<u>This option is not available for payment on a monthly basis.</u>***
Please make checks payable to CAREINGTON.

I authorize **CARE**INGTON *International* to bill my credit card or checking account for the plan I have selected plus a <u>one time</u> non-refundable application processing fee. This charge shall remain in force until I notify **CARE**INGTON *International* Corporation in writing of its cancellation. I understand the terms and conditions of the plan. I understand that this is a discount plan and NOT insurance.

X____________________________________ Signature required

For office use only **CICLTCC3-DV**	Member #	GRP **LTCC3-DV**	AGENT **LTCC**	SSUM# **9755**	MKT CODE	ALT CODE	EFF DATE

CAREINGTON CI/POS SERIES DENTAL – COLE VISION ONE– PROGRAM APPLICATION

Yes! Please start my dental and vision program immediately. I understand I'll have 45 days to use my plan absolutely risk free.
Mail applications to Long Term Consumer Care, Inc., N27 W23960 Paul Road, Suite 201, Pewaukee, WI 53072.
To join by phone, call (800) 544-9505 or by Fax (262) 523-1910. You may also Join online at www.ConsumerBenefits.net.

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY, STATE, ZIP	WORK PHONE
HOME PHONE	SOCIAL SECURITY #	DATE OF BIRTH
SPOUSE'S NAME (**IF INCLUDED**)	DATE OF BIRTH	
CHILDREN'S NAMES (**IF INCLUDED**) 1. 2. 3.	DATE OF BIRTH	**E-MAIL ADDRESS**

Please circle the desired coverage level:

Member Only	$7.95 monthly + One Time $10.00 Application Fee.	$79.95 annually + One Time $10.00 Application Fee.
Member Plus Family	$9.95 monthly + One Time $10.00 Application Fee.	$99.95 annually + One Time $10.00 Application Fee.
Effective Date – **Circle One:** *First of this month* or *First of Next Month*		

Choose One:

A. ☐ **Bill my credit card.**

☐ Visa ☐ American Express ☐ Mastercard ☐ Discover

Account #______________________ Expiration Date______________ Name on card____________________

B. ☐ **Bill my checking account.**

Bank/institution name:______________________________________

Name of account holder:______________________________________

Routing number:______________ Account number:____________________

Please remember to enclose a check for the appropriate amount. Checks payable to CAREINGTON.

C. ☐ **Use the enclosed check as payment.** ***<u>This option is not available for payment on a monthly basis.</u>***
Please make checks payable to CAREINGTON.

I authorize **CARE**INGTON *International* to bill my credit card or checking account for the plan I have selected plus a <u>one time</u> non-refundable application processing fee. This charge shall remain in force until I notify CAREINGTON International Corporation in writing of its cancellation. I understand the terms and conditions of the plan. I understand that this is a discount plan and NOT insurance.

X______________________________ Signature required

For office use only **CICLTCC2-DV**	Member #	GRP **LTCC2-DV**	AGENT **LTCC**	SSUM# **6913**	MKT CODE	ALT CODE	EFF DATE

TERMS & CONDITIONS

Renewal Conditions: By joining a plan, you are authorizing **CARE**INGTON to bill your credit card or checking account for the plan you have selected. This charge shall remain in force until you notify **CARE**INGTON *International* Corporation in writing of its cancellation. By joining, you are agreeing to the terms and conditions of the plan and adopting it for a minimum of one year. This plan will automatically renew at the end of your membership term on an annual basis, and your credit card or bank account will be automatically charged or drafted for the appropriate amount.
Termination Conditions: **CARE**INGTON *International* reserves the right to terminate plan members from its plan for any reason, including non-payment.
Cancellation Conditions: You have 45 days from the date you join to use the plan risk-free. If for some reason within 45 days you are dissatisfied with the plan and wish to cancel and obtain a refund of any membership fees paid, please send a cancellation letter and a request for refund with your name and member number to Member Services, **CARE**INGTON *International* at 7400 Gaylord Parkway, Frisco, Texas 75034. If **CARE**INGTON *International* is billing you quarterly, semi-annually or annually, **CARE**INGTON *International* will, in the event of cancellation of the membership by either party, make a pro-rata reimbursement of the periodic charges to the member.
Limitations, Exclusions & Exceptions: This program is a discount membership program offered by **CARE**INGTON *International* Corporation. **CARE**INGTON is not a licensed insurer, health maintenance organization, or other underwriter of health care services. No portion of any provider's fees will be reimbursed or otherwise paid by **CARE**INGTON. **CARE**INGTON is not licensed to provide and does not provide medical services or items to individuals. You will receive discounts for medical services at certain health care providers who have contracted with the plan. You are obligated to pay for all health care services at the time of your appointment. Savings are based upon the provider's usual and customary fees. Actual savings will vary depending upon location and specific services or products purchased. Please verify such services with each individual provider. The discounts contained herein may not be used in conjunction with any other discount plan or program. All listed or quoted prices are current prices by participating providers and subject to change without notice. Any procedures performed by a non-participating provider are not discounted. From time to time, certain providers may offer products or services to the general public at prices lower than the discounted prices available through this program. In such event, members will be charged the lowest price. Discounts on professional services are not available where prohibited by law. This plan does not discount all procedures. Providers are subject to change without notice and services may vary in some states. It is the member's responsibility to verify that the provider is a participant in the plan. At any time **CARE**INGTON has the right to eliminate a Participating Professional from the respective network in which they are associated and may substitute Provider networks at its sole discretion. **CARE**INGTON *International* cannot guarantee the continued participation of any provider. If he or she leaves the plan, you will need to select another provider. Providers contracted by **CARE**INGTON are solely responsible for the professional advice and treatment rendered to members and **CARE**INGTON disclaims any liability with respect to such matters. Services and service providers may change or be discontinued at anytime without notice.
Complaint Procedure: If you would like to file a complaint or grievance regarding your plan membership, you must submit your grievance in writing to: Member Services, **CARE**INGTON *International* at 7400 Gaylord Parkway, Frisco, Texas 75034.

Disclosure:

1) This plan is not a health insurance policy.
2) This plan provides discounts at certain healthcare providers for medical services.
3) This plan does not make payments directly to providers of medical services.
4) The plan member is obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have contracted with the discount medical plan organization.

This plan is administered by **CARE**INGTON *International* Corporation, 7400 Gaylord Parkway, Frisco, Texas 75034. The program and its administrators have no liability for providing or guaranteeing service or the quality of service rendered. Note to Utah residents: this contract is not protected by the Utah Life and Health Guaranty Association.