As of June 1, 2021

Allegra Health Association Enrollment Form

Individual, Family & Self-Employed

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by | **Requested Effective Date of Coverage/Date of Change**

Member ID #:

OptumRx ID #:

Reason for Application
(Check all that apply)

- ○ *New Member*
- ○ *Dependent Add/Delete*
- ○ *Change Name/Address*
- ○ *Current Member*

Enrollment Type
(Check all that apply)

- ○ *Individual*
- ○ *Self-Employed*
- ○ *Family*

A. Applicant Information

Last Name	First Name	MI	Social Security Number	Cell Phone:

Address	Apt #	City	State	Zip Code

Date of Birth	Sex	Language preference, if not English	* Email Address
06/30/2021	○M ○F		

Physician (PCP)* Please provide your existing Primary Care Doctor if applicable	*Broker/Agent - Name: Tel:

B. Family Information

List All Enrolling (Attach sheet if necessary)

Last Name	First Name	MI	Sex (M/F)	Relationship***	Birth date	Social Security Number

***Required Field**

Network access provided by " Aetna / First Health Network and Affiliates": Medical network provided by Aetna First Health Network (PPO, indemnity). Prescription access provided by Optum Rx. Telemedicine access provided by Teladoc.

*Important: You must use The First Health Network directory of providers, to choose your providers for yourself and each of your covered dependents. If you go-out-of network you are responsible for 100% of the cost of your medical services.

Applicant First Name: _____ Last Name:_____ DOB: _____

C. Allegra Association Plan Selection	(Plans Priced Per Member Per Month)		
60/40 Plans	Silver 60/40	Gold 60/40	Platinum 60/40
Price Per Month	$85	$99	$150
80/20 Plans	Silver 80/20	Gold 80/20	Platinum 80/20
Price Per Month	$105	$125	$189

One-time $25 Application and Administration Fee (Per Enrollment Application)

Payment Calculator	Initial Payment Only	Recurrent Monthly Payment
Applicant Selection Amount:	$	$
Spouse Selection Amount:	$	$
Dependent(s) Selection Amount (multiply by # of dependents)	$	$
One-time Application and Administration Fee	$25	N/A
Total Per Month:	$	$

1. Make personal check payable to "Five Points Benefit Plans, LLC." If your are returning the completed application by mail, send to:

   Five Points Benefit Plans, LLC
   6006 N. Mesa St. - Suite 108
   El Paso, Texas 79912

2. You may submit your new enrollment application by email to: Isaac@fivepointsmecplan.com

Cancellation Policy: Five business days prior to your payment date. No cancellation fee applies.

Please maintain a copy of this enrollment for your records.

Date	Signature of Applicant(s)
06/30/2021	

Auto-Recurring Payment Authorization Form

Credit Card Account

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

3 Digit Verification Code: _____

Type of Credit Card: **Master Card** ☐ **Visa** ☐ **Discover** ☐ **American Express** ☐

_____ _____

Signature of Enrollment Applicant Date

You authorize Five Points Health Benefit Plans, LLC regularly scheduled monthly charges to your checking/credit card account. A receipt for each transaction will be automatically emailed to you with the contracted fee amount you have agreed.

ACH Debit | Authorization Form

Five Points Benefit Plans, LLC

Payment Plan Authorization

Name: _____
Please print First Middle Last

Address: _____ Date of Birth: _____

City/State/Zip: _____ Last 4 digits of Social Security #: _____

Home Phone: (_____) _____ Driver's License #: N/A

Work Phone: (_____) _____ Driver's License State: N/A

Payment Plan Schedule

☐ One-time Payment Payment Amount: $_____ Payment Date: _____

☐ Recurring Debit every: _____ ☐ Day(s) ☐ Week(s) ☐ Month(s)

Start Date: Month: _____ Day: _____ Year: _____ Payment Amount: $_____
(Start date must be at least 15 business days from submission of this form)

End Date: Month: _____ Day: _____ Year: _____ Transaction Fee: $_____

Number of Payments: _____ Total Payment: $_____
(Payment Amount + Transaction Fee)

Customer Bank Account Information:

Bank: _____ Phone Number: (_____) _____

Routing Number: _____

Account Number: _____

Attach a voided check to this form.

Payment Authorization

I authorize my bank to debit my account as identified above to the terms stated here. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (Minimum 30 days).

I understand that if the total amount owed to the Service Provider is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed the Service Provider is paid off, or unless the plan is terminated earlier by me as above. I understand any added amounts can be applied for with a new ACH Debit Authorization Form.

All other changes such as payment amount, frequency, bank account number change, will require a new ACH Debit Payment Authorization Form to be filled out and submitted to Merchant 15 days prior to any change being implemented. I understand that this payment plan may be cancelled by the Service Provider or Merchant due to NSF (Non-sufficient Funds). I will be liable to pay an NSF fee of $25.00 (or the amount allowable by law), which may be automatically debited for each NSF.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this payment plan. I indemnify and hold the Service Provider, the bank, and Merchant harmless from damage, loss or claim resulting from all authorized actions hereunder.

Customer Signature: _____ **Date:** _____

Second Authorized Signature of Bank Account if Required: _____ **Date:** _____

A voided check from customer's bank account must accompany this authorization form.