Medical Savings PLAN

Membership Application

1410 Triad Center Drive St. Peters, MO 63376
Fax: 636-922-4619 Phone: 636-493-1789

Application Date _____

PRIMARY MEMBER Please answer all questions and print clearly

Last _____ First _____ MI _____ Birth Date _____

Address _____ Social Security # _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Work Phone _____ Fax _____

Accident Beneficiary _____ Relationship _____ Requested Start Date _____

ADDITIONAL FAMILY MEMBERS Please answer all questions and print clearly

	Last	First	M.I.	Social Security #	Date of Birth	Age	Sex
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

CHOOSE A PLAN		Single	Family	Monthly
☐ **A**ccident Plan up to $2500 in protection		$19.95	$24.95	
☐ **B**enefits Plan = Prescription, Dental, Vision, Hearing and Chiropractic Discounts		$14.95	$19.95	
☐ **C**ombo Package = Plan **A** + Plan **B**		$24.95	$29.95	
☐ **D**isability - Can be added to **A**ccident or **C**ombo $250 /week on $2,500 level $400/week $200/day Hosp indemnity on $5,000	+	$15.00	$15.00	
☐ **E**xtra Accident Plan Upgrade to $5,000 Can be added to **A**ccident, **C**ombo and **D**isability	+	$10.00	$15.00	
Total Monthly Dues	=			

Choose a Term

☐ **Monthly** — Bank Draft or Credit Card Only — monthly X 1 = _____

☐ **Semi-Annual** — Collect 6 Months — monthly X 6 = _____

☐ **Annual - 1 Month Free** — Collect 11 months — monthly X 11 = _____

One Time Enrollment Fee **$20.00**

Initial Amount Due $ _____

Please allow 7-10 business days for fulfillment.

_____
Applicant Signature

Baue Insurance Services / 5058358

Agent Signature *Agent #*

Payment Options

Bank Draft Authorization

I have provided a voided check and I realize with my signature below I authorize Medical Savings Plan to automatically draft my bank account each month in the amount of

$_____

Signature_____

Bank Routing #_____

Account # _____

☐ Checking ☐ Savings

Credit Card By signing below I authorize Medical Savings Plan to charge my credit card account for the initial amount due and For the monthly amount of $ _____

Signature_____ _____

Name on Card _____

Card # _____

Expiration _____

3 digit code_____

MasterCard ☐

Visa ☐