



ConTemporary Nursing / Allied / Private Duty  
**Dental / Vision / Prescription Drug DISCOUNT PLAN**  
 Complete Designated Fields and Fax to 866-767-7297



Your Access to  
 Affordable Health Care

**Member Application Form**

**The Discount Medical Plan Organization is The Capella Group, P. O. Box 610810 Dallas, TX 75261  
 Fax Number (972) 915-3283 Member Services Number (888) 411-3888**

F  
I  
L  
L

Last Name	First Name	M.I.	Birth Date	Sex	Social Security #
Address		Apt. #	City	State	Zip
Day Phone	Evening Phone	Email Address			
Representative #	Representative Name				

**Program Selection & Pricing**

<b>Med Plus</b> (Physician, Patient Advocacy, Prescription, Dental, Vision, Hearing, Chiro/Alt Med, Nurseline [not avail in CA])	Individual: \$44.95 /mo.	N/A
	Family: \$49.95 /mo.	
<b>Dental Plus</b> (Dental, Vision, Hearing, Prescription, Chiro/Alt Med, Nurseline [not avail in CA])	\$19.95 /mo.	\$19.95
<b>Prescription Plus</b> (Vision, Hearing, Prescription)	\$9.95 /mo.	N/A
<b>Add Your Mandatory Application Fee - (One-Time Non-Refundable Fee)</b> (Dental Plus or Prescription Plus Program App Fee is \$20.00, Med Plus is \$30.00)		+ \$20.00
<b>Total First Payment</b> <small>First payment must be made by check or credit card. Faxed applications processed only with check by fax or credit card.</small>		\$39.95

**All New Members Must Read and Sign Below:** The USA Healthcare Savings program **IS NOT** health insurance or a health insurance policy. The USA Healthcare Savings program provides discounts only at certain healthcare providers for healthcare services. The program holder is obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have contracted with The Capella Group. Prescription discounts are available only at participating pharmacies. The USA Healthcare Savings Program does not make payments to providers for medical services. Neither USA Healthcare Savings nor the networks accessed are responsible for providing or guaranteeing service and have no liability for the quality of service rendered. The program makes available, before purchase and upon request, a list of providers, including the provider's name, city and specialty. The range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received. If the member cancels the membership within the first thirty (30) days after receipt of the discount card and other membership materials, the member shall receive a reimbursement of all periodic charges paid. The return of all periodic charges shall be made within thirty (30) days of the date of the cancellation. The one time application fee is not refundable except in states where prohibited (see Terms and Conditions.) Discounts range from 10% to 60%.

I also authorize USA Healthcare Savings to deduct the periodic payments from my account as noted below:  
 This authorization will remain in effect until I revoke it in writing or cancel my membership.



Member Signature (REQUIRED) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ **ConTemporary Nursing** \_\_\_\_\_  
 Payer Signature if different than Member \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Premiums will be deducted monthly from your pay check.  
 \$39.95 the first month which includes the enrollment fee  
 \$19.95 each month thereafter.  
 The premium is the same no matter how many dependants you add below.

F  
I  
L  
L

**Dependents—Spouse, Children up to the age of 25, Parents in Household over age 60 and any Other IRS Dependents Only.**

Name (First, M.I., Last)	Sex	Date of Birth	Address (if different)	Relationship