Services recommended & marketed by:
Revenue Objectives Intl, LLC & Tele-Well Advisory

AMERIDOC℠
CALL · CARE · RESULTS

MEMBER ENROLLMENT FORM

NEW ENROLLEE – EFFECTIVE DATE:_____

(Check one)

COVERAGE LEVEL: ☐ **Individual** ☐ **Family**

PLAN SELECTION: ☐ **Plan A- $9.99** ☐ **Plan B- $12.99** ☐ **Plan C- $16.99** ☐ **Plan D-$19.99**

MEMBER INFORMATION

Member Name:_____ Gender: ☐ Female ☐ Male

SSN:_____ Date of Birth:_____

Mailing Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____

Email Address:_____

DEPENDENT INFORMATION (only complete if enrolling dependents in coverage)

	First Name	Last Name	DOB	Gender (M / F)
Spouse:	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____

I **agree to have the monthly cost of this plan deducted from my:** Credit Card* Bank Account

(*Payment by credit card requires prior authorization and must complete the information below).

Credit / Debit Card #:_____ **Exp. Date:**_____ **CVV Code** (3 digits on back of card**):**_____

Name as it appears on the credit card:_____

Billing Address (if different than address under Member Information above)**:**_____

Banking Institution: _____ **Authorized Signer:** _____

Routing/ABA #: _____ **Account #:** _____

By signing below, I and the individuals named herein have requested to enroll in this plan. I also understand that this plan is not health insurance and it is not intended as a substitute for health insurance. I also understand that the monthly cost will either be deducted by the Plan Sponsor from my paycheck or settlement check or by AmeriDoc from my credit card.

Member Signature:_____ Date:_____

Agent/Enroller Name (Please Print):_____ Date:_____

Secure Fax: 877.205.6438 **Phone:** 800.330.7846 **Email:** Contact_Us@RevenueObjectivesIntl.com