



**1203 Lake Street, Suite 210
Fort Worth, Texas 76102**

Application is hereby made to **Careington International**, by the Applicant, named below, hereinafter called “**Group**”, for the purpose of making available to individuals certain prepaid dental services and discounts issued by **Careington International**.

1. Complete Group Applicant Information

Company Name			
Address	Street	Suite	DBA
	City	State	Zip
Office Contact			Phone ()
Billing Contact			Phone ()

2. **The contract shall be effective 12:01 a.m., Central Time on _____.**

3. _____Contributory _____Non-Contributory

4. **Including:**

An employee of the Group who meets the requirements for service under the Group’s policies will be included for discount under this Contract.

A. Classes of members to be included: _____Active _____Retirees

B. Rules of Membership: _____

5. **Dental Care Services:** Dental Care Services are specified in Schedule of Services 500 Series.

Vision Care Services: EyeMed Vision Care

6. **Monthly Fee:** The monthly prepayment fee for the number of Members in each category below is due and payable from Group to **Careington International** beginning on the date specified in paragraph 2 of this Application, and on that same day for each month this contract continues in force. All services in Paragraph 5 are included in the monthly fees.

Employee Only:	\$	6.95
Employee & One:	\$	11.95
Employee & Household:	\$	15.95

This contract shall become effective 12:01 a.m. Central Time, on _____ and shall be automatically renewed at the end of each Contract period unless terminated by **Careington International** or the Group as provided herein. The first Contract period shall commence as of the effective date and shall terminate at 12:00 a.m., Central Time on _____ unless terminated before this date by **Careington International** or the Group. This Contract shall continue in force subject to earlier termination by **Careington International** for (a) the failure of the Group to pay the prepayment fee, subject to a thirty-one day grace period; and (b) sixty days written notice for cause.

SIGNED ON BEHALF OF THE APPLICANT:

APPROVED BY:

(Employer/Association)

CAREINGTON INTERNATIONAL

(Signature/Title)

(Stewart Sweda / Chief Sales and Marketing Officer)

(Date)

(Date)

GENERAL AGENT PROCESSING INFORMATION			
<input type="checkbox"/> Number of Applications: _____ <input type="checkbox"/> Number of Employees: _____ <input type="checkbox"/> Contract: 500 Series, EyeMed Vision Care <input type="checkbox"/> Check # _____ Amount \$ _____ <input type="checkbox"/> Monthly amount \$ _____ Other _____	App fee amount: \$ _____ per applicant/group Frequency (circle one): monthly quarterly annually Special Instructions:		
Managing Agent <p style="text-align: center; font-weight: bold; font-size: 1.2em;">QUALBE</p>	General Agent <p style="text-align: center; font-weight: bold; font-size: 1.2em;">DCRATZ</p>	Writing Agent <p style="text-align: center; font-weight: bold; font-size: 1.2em;">JHOSEZ</p>	Effective Date
OFFICE USE ONLY			
QBI Entered	By:	Group No. <p style="text-align: center; font-weight: bold; font-size: 1.2em;">ZDEM</p>	

TERMS & CONDITIONS

Renewal Conditions: By joining a plan, you are authorizing Careington to bill your credit card or checking account for the plan you have selected. This charge shall remain in force until you notify Careington International Corporation in writing of its cancellation. By joining, you indicate that you have read the terms and conditions of the plan and adopting it for 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: Careington 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, Careington International at 7400 Gaylord Parkway, Frisco, Texas 75034. If Careington International is billing you quarterly, semi-annually or annually, Careington 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 Careington International Corporation. Careington 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 Careington. Careington 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 normal 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 Careington 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. Careington 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 Careington are solely responsible for the professional advice and treatment rendered to members and Careington disclaims any liability with respect to such matters. Services and service providers may change or be discontinued at anytime with notice as required by law.

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, Careington International at 7400 Gaylord Parkway, Frisco, Texas 75034.

Disclosures:

1. **THIS PLAN IS NOT INSURANCE. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN.***
2. The plan provides discounts at certain health care providers for medical services. The range of discounts will vary depending on the type of provider and service.
3. The plan does not make payments directly to the providers of medical services.
4. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount medical plan organization.
5. Before purchase, you may access a list of participating health care providers at CareingtonProviders.com. Upon request the plan will make available a written list of participating health care providers.
6. You have the right to cancel within the first 30 days after receipt of membership materials and receive a full refund, less a nominal processing fee.
7. Discount Medical Plan Organization and administrator: Careington International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034; phone (800)372-7615.

Note to Texas Consumers: Regulated by the Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711; telephone (800)803-9202 or (512)463-6599 website: www.license.state.tx.us/complaints. The program and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. *Medicare statement applies to Maryland residents when pharmacy discounts are part of program. This program is not available in Vermont and Montana.