Kinetic Health was established in 2012 and is a health benefit membership plan. It is not an insurance product. Kinetic Health advocates on behalf of its members to obtain fair rates for medical care. Working together with providers, we are able to provide members with access to affordable quality health care through mutual support.

"KINETIC HEATLH PLAN" MEMBERSHIP APPLICATION

KINETIC HEALTH PLAN RATE: $99 per Individual, per Month
KINETIC HEALTH PLAN INCLUDES:

- **Virtual Primary Care, Urgent Care & Behavioral Health:** With LASO, get unlimited 24/7 virtual Telehealth care nationwide.
- **Labs:** With Quest Diagnostics, get unlimited access to routine labs with no additional costs at locations nationwide, except those in AZ and OK. **Some exclusions apply. See website for details.*
- **Prescription Savings:** With ProCare Rx, get direct savings on medications at most local pharmacies; and with Revive get free home delivery on 1,000+ generic medications with a 90-day supply.
- **Vision & Dental Savings:** With DocWellbee, get preventive care services, and standard dental and vision discounted costs.
- **Patient Advocacy:** When additional help or care beyond the plan is required, our Care Team is there to assist.

PRIMARY APPLICANT

Last Name			First Name		Middle Initial
Sex	Date of Birth (MM/DD/YYYY)	Social Security Number		DL# / State of Issue	Today's Date
Home Address			City	State	Zip
Mailing Address (if different than home address)			City	State	Zip
Primary Phone	Other Phone		Email Address		

PRIMARY BENEFIT SELECTION **Effective Date:** ______________________________

(The 1st of the month following enrollment.)

Add-On Benefits

$56 member ☐ **Catastrophic Coverage (Must have an approved Primary Care Provider (PCP) for this coverage.)**
Covers catastrophic medical events starting from 50K in paid claims to Unlimited at 130% of Medicare with no lifetime limits.

PCP Name: ______________________________

PCP Network/Practice: ______________________________

PCP Phone #: ______________________________

PCP Address: ______________________________

DEPENDENT'S BENEFIT SELECTION

☐ **ADD SPOUSE**

Last Name	First Name	Relationship to Primary	Gender	Date of Birth
Social Security Number	Primary Phone	Email Address		

Add-On Benefits

$56 member ☐ **Catastrophic Coverage (Must have an approved Primary Care Provider (PCP) for this coverage.)**
Covers catastrophic medical events starting from 50K in paid claims to Unlimited at 130% of Medicare with no lifetime limits.

PCP Name: ____________________

PCP Network/Practice: ____________________

PCP Phone #: ____________________

PCP Address: ____________________

☐ **ADD CHILD(REN)**

CHILD #1 ***(Children must be under 18 years old)***

Last Name	First Name	Relationship to Primary	Gender	Date of Birth

Add-On Benefits

$56 member ☐ **Catastrophic Coverage (Must have an approved Primary Care Provider (PCP) for this coverage.)**
Covers catastrophic medical events starting from 50K in paid claims to Unlimited at 130% of Medicare with no lifetime limits.

PCP Name: ____________________

PCP Network/Practice: ____________________

PCP Phone #: ____________________

PCP Address: ____________________

CHILD #2 ***(Children must be under 18 years old)***

Last Name	First Name	Relationship to Primary	Sex	Date of Birth

Add-On Benefits

$56 member ☐ **Catastrophic Coverage (Must have an approved Primary Care Provider (PCP) for this coverage.)**
Covers catastrophic medical events starting from 50K in paid claims to Unlimited at 130% of Medicare with no lifetime limits.

PCP Name: ______________________________

PCP Network/Practice: ______________________________

PCP Phone #: ______________________________

PCP Address: ______________________________

CHILD #3 ***(Children must be under 18 years old)***

Last Name	First Name	Relationship to Primary	Gender	Date of Birth

Add-On Benefits

$56 member ☐ **Catastrophic Coverage (Must have an approved Primary Care Provider (PCP) for this coverage.)**
Covers catastrophic medical events starting from 50K in paid claims to Unlimited at 130% of Medicare with no lifetime limits.

PCP Name: ______________________________

PCP Network/Practice: ______________________________

PCP Phone #: ______________________________

PCP Address: ______________________________

Total Add-Ons: $____________

Total Monthly Premium: $____________

(PLEASE NOTE: A one-time application fee of $20 is added to the first bill.)

SERVICES AGREEMENT

I agree to a one-year contract for with my selected Providers for access to services related to my chosen Plan. I understand any requests to change Providers prior to the end of my 12 month contract must be submitted in writing to be reviewed and approved by the Kinetic Health Member Services Department. I also understand that if I terminate this contract prior to 12 months, I am legally responsible for all the remaining payments due for the entire contract term.

Signature: ____ **Date:** __________________

(PLEASE NOTE: This Plan is NOT Insurance.)

KINETIC HEALTH MEMBERSHIP AUTHORIZATION

Choose your recurring payment date each month: ☐ **5th** ☐ **15th** ☐ **20th**

I (we) authorize Alliance MSO to collect these monthly charges. I (we) understand that in order to cancel these payments, I (we) must provide written notice to Alliance MSO no less than 30 days before the end of the contract year or that my contract will automatically be renewed for another term. Until such notice is received, I (we) agree that you shall be fully protected in honoring any such charge/draft.

TERMS AND AGREEMENT FOR BANK AUTHORIZATION

I (we) authorize the financial institution named below to honor and pay these membership charges. This authority is to remain in effect until revoked by me (us) in writing and until you receive such notice. I (we) agree that you shall be fully protected in honoring any such check/draft or credit/debit card charge.

METHOD OF PAYMENT: ☐ Bank Draft ☐ Debit ☐ Credit

FOR BANK DRAFT:

Bank Name: ____

Bank Routing #: ______________________________ Account #: ______________________________

FOR DEBIT OR CREDIT: ☐ MC ☐ Visa ☐ Amex ☐ Discover

Name on card: ____

Card #: ____ Exp Date: _____/_____ CSV Code: ________

Signature: ____ Date: __________________

I certify that I have given an outline of coverage for the policy applied for by this applicant.

Agent's Name (Print): ____

Agent's Signature: ____