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 cooperation and mutual support.

"KINETIC HEATLH PLAN" MEMBERSHIP APPLICATION

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

KINETIC HEALTH PLAN INCLUDES:

- **Primary Care, Urgent Care and Behavioral Health:** With LASO, get unlimited 24/7 virtual care nationwide with no additional costs.
- **Labs:** With Quest, get unlimited nationwide access to routine labs with no additional costs. (Some labs excluded. See website for details.)
- **Mental Health:** With eHome, get confidential video counseling from licensed counselors nationwide.
- **Prescriptions:** With ApproRx, get direct savings on medications at most local pharmacies; and with Magic Pill get free home delivery on 1,000+ generic medications with a 90-day supply.
- **Patient Advocacy:** When additional help or care beyond the plan is required, our Care Team is there to assist.
- **24/7 Care Connection:** Through the Drive Health app, AI Nurse Clara is there anytime to assist with coordinating plan services.

PRIMARY APPLICANT

Last Name		First Name		Middle Initial
Sex Female	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
			Female	
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
			Female	

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 Female	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 Female	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: _____

SUBMIT APPLICATION