



TBT Co-op Clinics  
 P.O. Box 1838  
 Splendora, TX 77372  
 Fax: 866-234-8707  
 Office: 866-549-4199

Agent Name: \_\_\_\_\_ # \_\_\_\_\_

**PATIENT/PHYSICIAN COOPERATIVES MEMBERSHIP APPLICATION**

Primary Applicant's Last Name	First Name	M	Age	Birth Date (MM/DD/YYYY)
Residence Address		City		State
Mailing or Billing Address (if Different than Residence)		City		State
Home Phone	Work Phone	Cell Phone		
E-mail Address			Social Security # or Other ID #	

**MEMBERS OF HOUSEHOLD AND BENEFIT SELECTION**

										Benefit Codes									
Last Name	First Name	M	Relationship To Primary	Sex	DOB (MM/DD/YYYY)	Tobacco (Y/N)	COOP	CL1	CL2	CL3	LAB	CD	GH1	GH2	GA	GCI	Primary Care Provider Name	Primary Care Provider Phone #	
*Primary Member Name Shown Above*					Shown Above														
2.																			
3.																			
4.																			
5.																			
6.																			

Beneficiaries' Names For Members Primary \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 #4 \_\_\_\_\_ #5 \_\_\_\_\_ #6 \_\_\_\_\_

**TERMS AND AGREEMENTS:**

Agreement for automatic bank draft (Attach a voided check to this application)

I (we) authorize the financial institution named below to honor and pay these monthly charges. This authority is to remain in effect until revoked by me (us) in writing, and until you actually receive such notice, I (we) agree that you shall be fully protected in honoring any such check/draft. I (we) understand that in order to cancel these automatic deductions, I (we) must provide written notice to the Senior Patient Association no less than 15 days before the next scheduled automatic deduction in writing.

Account Holder Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Requested Effective Date \_\_\_\_\_

**Agreed Initial Charges/Payments Collected**

Billing Method: \_\_\_\_\_ Amount: \_\_\_\_\_ Check # \_\_\_\_\_  
 CHECK  CREDIT  DEBIT  DRAFT

**Agreed Monthly Charges**

Billing Method: \_\_\_\_\_ Amount: \_\_\_\_\_ Billing Day: \_\_\_\_\_  
 DRAFT  CREDIT  DEBIT  ANNUAL  1st  5th  10th  15th

Account Name (Print Clearly) \_\_\_\_\_

Bank Name \_\_\_\_\_ Bank Routing Number \_\_\_\_\_

Checking Account Number \_\_\_\_\_

Name on Credit/Debit Card	Credit/Debit Card Type <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMEX <input type="checkbox"/> DISCOVER <input type="checkbox"/> OTHER
Credit/Debit Card Number	Credit/Debit Card Expiration Date _____ / _____ CVV Code # _____

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

COOP=Co-op Membership  
 CL1=PCP Services w/ Co-pay  
 CL2=PCP Services w/o Co-pay  
 CL3=PCP Services w/o Co-pay (Group Insurance required)  
 LAB=Lab Services  
 CD=Diagnostic-Radiology Services  
 GH1=\$25,000 Group Hospital Indemnity  
 GH2=\$2,000,000 Group Hospital Indemnity  
 GA=Group Accident Expense Insurance  
 GCI=Group Critical Illness Insurance

**DECLARATIONS AND SIGNATURES RELATED TO MEMBERSHIP AGREEMENTS  
PRECEDING THIS PAGE**

**I chose to participate in the following list of plans sponsored by the Association (PPC) for each household member as I have listed them in the application for each applicable plan:**

- \_\_\_ MEMBERSHIP in PPC and PRESCRIPTION DRUG CARD
- \_\_\_ AGREEMENT FOR PRIMARY CARE PHYSICIAN SERVICES PAYMENT PLAN
- \_\_\_ AGREEMENT FOR DIAGNOSTIC FACILITY PHYSICIAN SERVICES PAYMENT PLAN
- \_\_\_ GROUP HOSPITAL INDEMNITY INSURANCE (\$25,000)
- \_\_\_ GROUP HOSPITAL INDEMNITY INSURANCE (\$2,000,000)
- \_\_\_ ACCIDENT EXPENSE INSURANCE
- \_\_\_ CRITICAL ILLNESS INSURANCE
- \_\_\_ LAB SERVICES

**Section 1: SENIOR PATIENT ASSOCIATION DBA PATIENT/PHYSICIAN COOPERATIVES (PPC) BY LAWS**

I agreed to be a member of the Senior Patient Association in order to have access to the benefits and privileges of the Association and it's Co-op Medical clinic programs and group health insurance plans. I, therefore, approve of the By-laws which have been reported in this paper and to all of the terms and conditions stated herein.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: AGREEMENT FOR PRIMARY CARE PHYSICIAN SERVICES PAYMENT PLAN**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Primary Care Provider \_\_\_\_\_ (Signature on File) Date \_\_\_\_\_

**Section 3: AGREEMENT FOR DIAGNOSTIC FACILITY PHYSICIAN SERVICES PAYMENT PLAN**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Diagnostic Facility \_\_\_\_\_ (Signature on File) Date \_\_\_\_\_

**Section 4: AGREEMENT FOR LAB SERVICES PAYMENT PLAN**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**GROUP HOSPITAL INDEMNITY INSURANCE (\$25,000)**

I hereby apply for **GROUP HOSPITAL INDEMNITY INSURANCE**. I understand that if accepted by the Insurance Company, the insurance will become effective on the Effective Date shown in the Schedule of Benefits of the Certificate to be issued to me by the Insurance Company.

I declare that, to the best of my knowledge and belief, all of the information contained in this Enrollment Form, is true and correct, and that no material information has been withheld or omitted.

**WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

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

Agent Name (Print) \_\_\_\_\_ Agent Signature \_\_\_\_\_ Agent No. \_\_\_\_\_

\*The \$2,000,000 GROUP HOSPITAL INDEMNITY POLICY is NOT underwritten for employee group of 50 and more employees when employer pays at least 75% of employee premium. Group of 1-4 person(s) and 5-49 persons must complete the medical questions on the form for their respective group's size.