



OMNI Medical Card Enrollment Form

FILL IN THE INFORMATION REQUESTED PLEASE PRINT

First Name _____ MI___ Last Name _____ Male Female

Date of Birth /./ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Daytime Phone (.) _____ Evening Phone _____

GOLD PACKAGE
\$24.95 per month

Discount Medical Benefits
Vision Care
Dental Care
Hearing
Physician Care
VIP Health
Hospital
Long-Term! Elder Care

Non-Medical Discount Benefits
Retail Pharmacy
Mail Order Pharmacy
Fitness Club
Medifile

SILVER PACKAGE
\$19.95 per month

Discount Medical Benefits
Long-Term/Elder Care
VIP Health
Dental Care

Non-Medical Discount Benefits
Retail Pharmacy
Mail Order Pharmacy
Fitness Cub
Medifile

BRONZE PACKAGE
\$19.95 per month

Discount Medical Benefits
Vision Care
VIP Health
Hearing
Dental Care

Non-Medical Discount Benefits
Retail Pharmacy
Mail Order Pharmacy
Fitness Club
Medifile

I understand this is NOT INSURANCE and this program is not being sold to replace insurance.

SIGN HERE _____

** There will be an additional one-time application fee of \$10.00.
**Two membership cards are issued with each membership. If you wish to receive additional cards for immediate family, please enclose \$2.50 per card*



Cardholder #1:Name: _____
 Cardholder #2 Name: _____
 Cardholder #3 Name: _____
 Cardholder # 4 Name: _____

Please check the plan you wish to participate in.

Gold Plan \$24.95 **Silver Plan \$19.95** **Bronze Plan \$19.95**

Plan Price \$ _____

___ Additional cards @2.50 each \$ _____

One time Enrollment Fee \$ 10.00 _____

Total Due \$ _____

Method of Payment: Please Circle One

Check Money Order Visa MasterCard Discover American Express

Credit Card Holders Name _____

Account # _____

Expiration _____ CCVNumber (found on front or back of card) _____

Please Charge My Credit Card (Please Circle) Annually Quarterly Monthly

BANK DRAFT:

I HEREBY AUTHORIZE New Benefits, Inc. to initiate funds transfers from the depository financial institution account indicated below and authorize my depository financial institution to honor those transfers. Debit my payment of \$ _____ on the 20th of each month prior to my due date. Please enclose your first TWO MONTHLY payments and a VOIDED CHECK with this application.

Account Holder Name _____

Checking or Savings (please circle)

Name of Bank _____

Address _____ City _____ ST _____ ZIP _____

ABA# _____ Account # _____

Additional Terms and Conditions: I understand that this agreement will remain in effect until New Benefits, Inc. has received a written notice from me that it should be cancelled. To ensure prompt cancellation of my New Benefits, Inc. program this notice must be submitted at least 15 days, but not less than 3 days prior to my next scheduled payment date.

Name _____

Signature _____

Group#_1650134 IC# 6558—009

Discount Medical Plan Organization:
 Newbn Inc.
 14240 Proton Rd.
 Dallas, TX 75240