Membership Payment Form

A Discount Plan Dedicated for Your Healthcare Solutions

Effective Date:	
New ☐	Reenrollment ☐

Person Responsible for Payment

First Name	MI	Last Name	Date of Birth

Billing Address	City	State	Zip Code

Telephone	Email

Applicant

First Name	MI	Last Name	Date of Birth

Payment Form

Check ☐ Debit Card ☐ Cash ☐ Money Order ☐ Credit Card ☐ EFT ☐

Visa ☐ Master Card ☐ AMEX ☐ Discover ☐

Credit Card Number	Exp. Date	Security Code

Note: Complete & BMP Plus Plans only form of payment accepted is EFT/Automatic withdraw payment.

Plan Selection

Core	☐	Single	☐
CorePlus	☐	Family	☐
		Single	☐
Complete	☐	Couple	☐
BMP Plus	☐	Family	☐

Membership Fee

Core - Quarterly	$
Core - Semi Annual	$
Core - Annual	$
CorePlus - Quarterly	$
CorePlus - Semi Annual	$
CorePlus - Annual	$
Complete -Monthly	$
BMP Plus - Monthly	$
Enrollment Fee	$
Total Amount	$

Disclosure

EFT AUTO BILL PAY INFORMATION

The undersigned hereby authorizes Best Medical Plan, Inc., to automatically debit or charge the account listed above for payment of the membership fees that are due according to the selected plan. The authorization is to remain in full force and effect until Best Medical Plan, INC. has received written notification requesting termination of the membership.

MEMBERSHIP CANCELATION POLICY

You may cancel your Best Medical Plan, Inc., membership at any time. Best Medical Plan, Inc., has a thirty (30) day cancellation policy. Best Medical Plan, Inc. must receive written notification requesting membership cancellation at least thirty (30) business days in advance of the next billing cycle for you not to be charged for the upcoming billing cycle. If you have prepaid any Membership Fees for the Core or CorePlus plans the prepayment will be refunded on a prorate basis for the months, the membership that has not been used, not including the one-time non-refundable Enrollment Fee which was charged at the time of the Membership Enrollment. The Enrollment Fee is non-refundable on all plans. For membership cancellation please contact Best Medical Plan, Inc. at (305) 800-2378, Monday through Friday, between the hours of 9:00am to 5:00pm,est. on email BMP at info@bestmedicalplan.us and a BMP associate will assist you.

Applicant's Initials: x _____

Sales Representative Name: _____ BMP SRN: _____ Sales Rep. Signature:_____

Account Holder Signature: _____ Date: _____