☐ ENGLISH ☐ SPANISH

First Class
• BENEFITS •
Living, Playing & Working First Class

FIRST CLASS HEALTH APPLICATION

HEALTH CARE ENROLLMENT FORM-PRINT CLEARLY

Last Name or Company Name	First Name	Date of Birth	Sex
Social Security Number/Federal Tax ID#		Email	
Address	City	State	ZIP
Day Phone	Evening Phone	Cell Phone	

ENROLLER INFORMATION (PRINT CLEARLY)

Affiliate ID #	Name

MEMBER ENROLLMENT SECTION

Faxed, Mailed or Online Applications processed only with Check or Credit Card Orders Only

All New Members Must Read and Sign Below:

I know the "First Class Health Card" is not an insurance plan. I also understand that I have to access contracted networks to receive program savings. I agree to pay all network providers at time of service and understand that the First Class Health Card is a 100% co-pay plan. I agree and will abide by the First Class Health Card Terms & Conditions. I know no portion of any provider's fees will be reimbursed or otherwise paid by FCBI, its affiliates or its provider's and that savings are based upon the provider's usual and customary fees. I know actual savings will vary depending upon location and specific services and products purchased.

☐ First Class Health - $29.95 per month (covers Dependents**) PLUS $149.95 one time set up fee **OR**	$149.95
☐ First Class Health ***PLUS*** - $49.95 per month (covers Dependents**) PLUS $149.95 one time set up fee	$149.95
☐ Additional Cards (add $10.00 per card) Send ______________ Cards one time, non refundable charge, please fill out below	**+**
TOTAL FIRST PAYMENT	

I agree to the First Class Health Terms & Conditions. I agree not to contact a network provider except to make an appointment for medical services. I authorize FCBI to deduct and/or charge my membership payments for the program(s) selected above each month from the bank account attached or credit card I have listed below.

X ____ Date: ____________________

Signature-I have legal authority to enter into this agreement

PLEASE CHECK BOX WHICH TYPE OF PAYMENT YOU ARE USING:

PLEASE, NO SAVINGS ACCOUNTS →

- ❑ **MASTERCARD**
- ❑ **VISA**
- ❑ **AMERICAN EXPRESS**
- ❑ **CHECK (Please attach with form)**

CARD NUMBER:	AMOUNT:
SECURITY CODE: (Visa & M/C - Last 3 digits that appear after your 16-digit credit card number in the signature panel on the back of your card **OR** AMEX - The four digit number that appears on the left side above your imprinted 15-digit card number on the front of your card)	BILLING PHONE #:
NAME AS IT APPEARS ON CARD:	EXP. DATE:
BILLING ADDRESS OF CREDIT CARD HOLDER:	SIGNATURE:

**Dependents include-Spouse, Children up to the age of 25, Parents in Household over age 60 and any other IRS Dependents Only.

ADDITIONAL CARDS (Attach extra sheet if needed)

Name (First M. Last)	Sex	Date of Birth	Address if Different	Relationship

FAX: TOLL FREE to: 1-877-612-0450

MAIL: First Class Benefits, 650 Airpark Road, Suite A, Napa Valley, CA 94558