TelaMed inc.

Discount Medical Plan Application Summary

Plan: Preferred Plus - $12.00
Benefits: Teladoc (no consult), Dental, Vision, Pharmacy, Diabetic Supplies, Durable Medical Equipment, Hearing Aids, MRI & CT Scans, Lab Testing and Vitamin Discounts

Disclosures:

This plan is NOT insurance.

This discount card program contains a 30 day cancellation period.

LA, MS, ND, OK, RI, SC, SD and TX residents: Member shall receive a full refund of membership fees, excluding registration fee, if membership is cancelled within the first 30 days after the effective date. AR and TN residents: A refund of all fees will be issued if membership is cancelled within the first 30 days. MD Residents: The membership fee and one-time registration fee (minus $5.00) will be refunded if cancelled within the first 30 days and upon return of the discount card.

MA Residents: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00.

Discount Medical Plan Organization: New Benefits, Ltd., Attn: Compliance Department, PO Box 671309 Dallas, TX 75367-1309.

Pharmacy discounts are Not Insurance, and are Not Intended as a Substitute for Insurance

The discount is only available at participating pharmacies.

The program administrator may obtain fees from pharmacies based on your prescription drug purchases. These fees may be retained by the program administrator or shared with you and/or your pharmacy.

Not available to residents of KS, UT, VT, WA and AR

TelaMed + inc.

Payroll Deduction Authorization
Discount Medical Plan Application

Agent: South Group Insurance	**TM+ ID:** LBC059	**Date:**

Internal Use Only

Company Name: Desoto County Schools		Social Security Number:
First Name:	MI:	Last Name:
☐ Male ☐ Female Date of Birth:	Email:	
Address 1:	Address 2:	
City:	State:	Zip Code:
Home Phone:	Mobile Phone:	
Plan: Preferred Plus **Benefits:** Teladoc (no consult), Dental, Vision, Pharmacy, Diabetic Supplies, Durable Medical Equipment, Hearing Aids, MRI & CT Scans, Lab Testing and Vitamin Discounts		
Card Program Cost (per month): $12.00	**Membership Effective Date:**	

Employee has the right to discontinue any above program at any time with thirty (30) days advance notice. The undersigned Employee agrees to the conditions printed above and assumes no liability other than as specified.

I hereby authorize my employer to deduct from my earnings such amounts as may now or hereafter be payable by me under the discount plan purchased through Tela Med Plus, Inc. I also acknowledge all rates are deducted from my paycheck post-tax. By signing below I confirm receipt of plan disclosures at the time of application.

_____ _____

Employee Signature Date

_____

Printed Name