GOLD MED PLAN

Member #

1435 W 49 Place
Suite 400B
Hialeah FL 33012

421 SW 107th Avenue
Miami, FL 33174

Phone: 305.823.5730
Fax: 305.823.5732

MEMBERSHIP APPLICATION

Date: _____ Plan: _____

Last Name:	First Name:
Address:	
City:	State / Zip Code:
Home Phone:	DOB:
Email	

Gold Med Membership is not a Medical Insurance neither an HMO or DMPO (Discount Medical Plan Organization) and does not provide any insurance coverage. The patient is obligated to pay up for the health services received and does not guarantee discount for other supplies.

1. **Term of Agreement**. The term of this Agreement may be semi-annual or annual and will be renewed upon termination of the current term for the same length term upon timely payment by member of the applicable membership fee.
2. **Renewal of Agreement**. The term of this agreement will automatically renew, unless the member send a termination letter requesting cancelation within 30 days.
3. **Cost of Membership**. Members monthly fee for an individual membership is $25.00 Monthly. Members fee for a Group plan max of 4 members is $40.00 per Family. Additional members will pay extra $10.00. Monthly Cash members subject to $10.00 processing fee.
4. **Services**. The Health Care services offered to Member pursuant to this agreement include PCP $25.00 copayment. Additional services such us Diagnostic Testing and laboratories at the fee schedule rate.

Please select:

Payment Periods:	Monthly	Semi-Annual	Annual
Payment Method	Visa	MasterCard	Cash
Credit Card #		Sec Code	Exp Date
I hereby authorize Gold Med Plan to charge my credit card the monthly rate for my Membership.			
Holder Member Signature:		Date:	Amount:

_____ _____

Member Signature Printed Name

*** IN CASE OF EMERGENCY CALL 911***

White: Gold Med Membership Plan Yellow: Member

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MEMBERSHIP APPLICATION-FAMILY PLAN ONLY

Effective Date: _____

Please provide the following to add family members to your Plan.

Member Last Name	Member First Name	DOB	Sex

I hereby authorize Gilda Gold Med Plan to charge my credit card the monthly rate for my Family Plan Membership.

_____ _____

Applicant Signature Printed Name

*** IN CASE OF EMERGENCY CALL 911***