



Care Alternative Repatriation Enrollment Form

Administered by: Medical Management Group
In Conjunction with David Macgregor Company
Customer Service: 866-641-2622
Fax # 973-448-9946

Affiliated Organization: Frugal George

Chapter/Location: _____

Section I: Personal Information (Required)

Last Name: _____ First Name: _____

Phone Number: _____ Gender: _____

Address (Include Apt #): _____

City / State / Zip: _____

Birthday (MM/DD/YYYY): _____ Email Address: _____

Drivers License Number: _____ State: _____

Section II: Beneficiary Information Required

Beneficiary Name: _____

Relationship: _____

Please list your beneficiaries full contact details including Country, State/Province, City/Village, Street Address and Telephone Number

Section III: Program Information (Required)

- Repatriation Program
- \$15.00 Per Policy Holder / Month

There is a \$10.00 One Time Processing Fee on all Care Alternative Programs

**Mail to: Care Alternative North America,
181 Howard Blvd, Suite M-405, Mt. Arlington, NJ 07856
www.FrugalGeorge.carealternative.com**

Section IV: Signature Required for any Program Selected

Notice: Any person who knowingly and with intent to injure, defraud or deceive CARE ALTERNATIVE NORTH AMERICA, who files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison. Any written or oral misrepresentation or warranty made in this application by the applicant or in the applicant's behalf, may, at the sole determination of CARE ALTERNATIVE NORTH AMERICA, be deemed material and defeat or void the CARE ALTERNATIVE NORTH AMERICA Certificate of Benefits and/or prevent its attaching.

Applicants Signature: _____ Date: _____

Section V: Monthly Payment Information (Required)

- Credit Card (Select Type) Cash Payments
- Visa American Express **BilleTEL** MasterCard
- MasterCard Discover

Name on Card: _____

Card Number: _____ Expiration (MM/YYYY): _____

Verification PIN: _____

As a convenience to me, I hereby request and authorize Claims & Benefit Management, Inc/for Care Alternative, herein after called COMPANY, to initiate credit card debit entries and/or collection entries to my credit card account. I agree that the COMPANY's rights in respect to each such charge shall be the same as if it were a check drawn on COMPANY and signed personally by me. This authority is to remain in effect until Claims and Benefit Management, Inc/for Care Alternative has received 30 days written notification from me of termination in such time and in such manner as to afford Claims & Benefit Management, Inc/for Care Alternative, reasonable opportunity to act upon it. Termination notification must be made a minimum of 30 days and will take place on the last day of the month following that 30 days notification.

I further agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, Claims & Benefit Management, Inc/for Care Alternative, shall be under no liability. I further agree any medical claims paid during this period will be reimbursed to the COMPANY.

I am aware and agree that the charge will be processed and recur on the 25th day of each month for the next month.

Authorizing
Signature: _____ Date: _____

Print Name: _____

MEMBERSHIP CANCELLATION PROCEDURE:

Claims and Benefit Management will process all cancellations within 7-10 business days of receipt. Your cancellation effective day will be the last day of the month in which you submit your cancellation request. If you cancel prior to the effective date of membership, you will receive a full refund. If you cancel within the month, no refund is due. All cancellations are subject to a \$35 processing fee. All requests for cancellation of membership must be addressed in writing and sent to:

Membership Cancellation Department

PO BOX 1606, ONTARIO CA 91762

Fax: 1-909-287-0768

Email: cancel@cbmtpa.com

There is a \$10.00 One Time Processing Fee on all Care Alternative Programs

Mail to: Care Alternative North America,

181 Howard Blvd, Suite M-405, Mt. Arlington, NJ 07856

www.FrugalGeorge.carealternative.com



Formulario de Inscripción de Repatriación de Care Alternative

Administrado por: Medical Management Group
En conjunto con David Macgregor Company
Servicio a Clientes: 866-641-2622
Fax # 973-448-9946

Organización de Afiliación: Frugal George

Iglesia / Parroquia: _____

Sección I: Información Personal (Necesitar)

Apellidos: _____ Nombre: _____

Teléfono #: _____ Sexo: _____

Dirección (Incluyas Apt #): _____

Ciudad /Estado / Zip: _____

Fecha de Nacimiento (MM/DD/YYYY): _____ Correo Electrónico: _____

Número de Licencia de Conducir: _____ Estado: _____

Sección II: Beneficiario de Información (Necesitar)

Nombre del Beneficiario: _____

Relación: _____

Haga una lista de sus beneficiarios incluyendo todos los datos de contacto País, Estado / Provincia, Ciudad / Pueblo, Dirección y Teléfono

Sección III: Información de Programa (Necesitar)

Programa de Repatriación

\$15.00 por mes por miembro asegurado

Se aplica un cargo único de procesamiento de \$10 dólares por afiliarse a CUALQUIER programa de Care Alternative

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