Tennessee
Hospitality & Tourism
Association

Individual TeleHealth with Pharmacy Discount Card Application

Company Name:_____

First Name:_____**MI:**_____ **Last Name:** _____

Address: _____

City:_____ **State:**_____ **Zip:** _____

Personal Phone #:_____ **Date of Birth:**_____

Personal Email: _____

Applicant Type:

TnHTA Member and Immediate Family – **Choose One**: ☐ $6.95 Per Month OR ☐ $79.00 Annually

Plan Includes:

TeleHealth with $0 Medical Consult Fee and Pharmacy Discount Card
(Benefits include member/employee and immediate family – Pharmacy cards can be used by anyone at any time)

Disclosures:

This plan is NOT insurance. This program contains a 30-Day cancellation period. 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. The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act or Massachusetts M.G.L. c. 111M and 956 CMR 5.00. These packages are not available to residents of VT and WA.

Terms & Conditions and Refund Policy:

1. Member is defined as primary member, spouse, and all legal dependents.
2. Providers are subject to change without notice. Programs may vary in some states. Providers and locations may be removed from the network at any time.
3. The program may be cancelled or modified at any time. You will receive notice if the plan is cancelled or materially modified.
4. MDLIVE customer service can be reached at 800.400.6354.
5. This program is a referral plan, and makes no warranties concerning the quality of care received. Providers are responsible for the professional advice and treatment provided to members.

Applicant Signature:_____ **Date:**_____

Group # (Assigned by Administrator):_____

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Payment Information:

☐ I choose to pay by electronic draft

Account Holder:_____ **Type:** ☐ Checking ☐ Savings

Name of Bank (Include City & State): _____

ABA Routing Number (#s at Bottom of Check):_____

Account Number: _____

Confirmation:

I authorize Insurance Planning and Service Company, LLC (IPSCO) to initiate debit entries electronically to my account indicated above and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until IPSCO has received notification from me of its termination in such time and in such manner to afford IPSCO and the depository/institution a reasonable opportunity to act on it.

Applicant Signature:_____ **Date:**_____

Return completed application via mail, fax or email to:

IPSCO
6505 Lee Highway
Chattanooga, TN 37421

P: 800.347.1109
F: 866.791.2806
E: IPSCO@assoc-admin.com