



College Membership Application

Discount Medical Plan Application

Complete this application and fax or mail to the address below.

Primary Card Holder Information

Last Name **D.O.B:**

First Name **M.I.**

Home Address

City

State **Zip Code**

Telephone

Email

School Name

School ID #

Spouse and Dependents

Name: **D.O.B**

Name: **D.O.B**

Name: **D.O.B**

CHP26435C

Co-Health College Product Plans

	Single Fee	Family Fee	Total
Student Basic Plus (includes Chiropractic)	\$82.00	\$98.00	<input type="text"/>
Student Basic Plan (Dental, Vision, Pharmacy)	\$62.00	\$78.00	<input type="text"/>
Dental & Vision	\$52.00	\$69.00	<input type="text"/>
Dental & Pharmacy	\$52.00	\$69.00	<input type="text"/>
Vision & Pharmacy	\$30.00	\$40.00	<input type="text"/>
Dental Only	\$40.00	\$60.00	<input type="text"/>
Chiropractic Only	\$25.00	\$45.00	<input type="text"/>
Vision Only	\$15.00	\$20.00	<input type="text"/>
Pharmacy Only	\$15.00	\$20.00	<input type="text"/>
<i>Additional ID cards available @ \$3.00 each Quantity</i> <input type="text"/>			<input type="text"/>
Totals			\$ <input type="text"/>

Payments -Mail or Fax enrollment form to address below
Make Checks payable to Co-Health Benefits

Check () Money Order () MasterCard () Visa ()

Other () _____

Card # **Expiration Date**

Signature: _____

Date: _____

Co-Health Benefits Plan

110 William Street, 22nd Floor New York, NY 10038

Telephone 212 271-0221 800 373-0881

Fax: 212 271-0224

