



Discount Medical Plan Application

College Membership 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

Co-Health College Product Plans

	Single Fee/Yr.	Family Fee/Yr.	Total
Dental & Vision	\$52.00	\$69.00	_____
Dental Only	\$40.00	\$60.00	_____
Vision Only	\$15.00	\$20.00	_____
Additional ID cards available @ \$3.00 each Quantity ___			_____
Totals			\$ _____

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

Check () Money Order () MasterCard () Visa ()
Other () _____

Card # Expiration Date

Signature: _____

Date: _____

CHP26435C

Co-Health Benefits Plan

110 William Street, 22nd Floor New York, NY 10038
Telephone 212 271-0221 800 3373-0881 Fax: 212 271-0224
www.cohealthusa.com/yale

DISCLOSURES

- This plan is NOT insurance. This discount card program contains a 30 day cancellation period.
- FL, LA, MD, ND, OK, 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.
- Discount Medical Plan Organization: New Benefits, Ltd. 14240 Proton Rd. Dallas, TX 75244.
- Pharmacy discounts are Not Insurance, and are Not Intended as a Substitute for Insurance
- The discount is only available at participating pharmacies.
- Dental Benefit is not available to VT residents.
- Chiropractic Benefit is not available to VT residents.
- Vision Benefit is not available to VT residents.