Group Activation and Payment Authorization Form

Group Billing Information

Group Name

EIN / Tax ID #

Address

City State Zip Code

Invoice Delivery Preference:

Group Administrator ☐ E-Mail ☐ Mail

Phone # E-Mail

# of Members Enrolling / # Eligible

Effective Date*

*Effective Date should be on the 1st of the month. Special exemptions can be made at client's request.

Products and Pricing

Plan:

Telemedicine Plan	☑
Rx Savings	FREE
Medical Bill Negotiation	FREE

Billing Cycle:

Monthly ☐ Annually ☐

Employer Paid: ☒

Cost Per Member Per Month	One Time Set up Fee/Member
	$3.95

Voluntary: ☐

Pay Intervals (check one): Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☒

First Payroll After Effective Date:

Ship New Member Letters to: Members' Personal Address ☐ Group Administrator ☐

Payment Method

Credit Card ☐ ACH / AutoDraft ☐ Check ☐

Name of Account Holder CVV Code Exp Date

ACH account & routing #s / Card # Estimated Payment

ACH Bank Name ACH Bank Address

Group Enrollment Terms

You hereby authorize AllyHealth to charge you by the above-referenced payment method. You also hereby authorize AllyHealth, its agents, affiliates, and vendors, to offer our services to your eligible employees/members subject to the following terms and conditions:

1. You agree to provide us with census data if needed for us to determine proper enrollment eligibility.
2. For voluntary enrollments, you agree to provide a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
3. We customarily bill you around the 1st of each month for services to be provided in that month. You agree to forward the membership fees due to us by the 25th of each month for the month in which you are billed.
4. This Agreement is subject to the Group Terms and Conditions, which are available for download and print from the following location: www.allyhealth.net/group-terms-conditions/

I agree that no member services will be effective until approved by us at our administrative office.

Approval

Signature _____ Date

Printed Name Phone Number

Title E-Mail Address

Agent Name **AllyHealth Agent #** **Phone #**

Submit completed form online to:

http://www.allyhealth.net/neworders