



WhealthCare

MEMBER ENROLLMENT FORM

Mail to SAAGII, Inc., 3940 Freedom Circle, Santa Clara, CA 95054, USA or Fax at (408) 200- 7499
For assistance please call Customer Service at 1-877-422-2422, (408) 200- 7431

Section 1: Personal Information (Primary Member)

** Required Information*

Name* Last _____ First _____ Middle _____

Home or Work address* _____ Apt./Ste.# _____ City* _____

State* _____ Zip* _____ County _____ Sex* Female Male Date of Birth* _____ / _____ / _____
Month Day Year

Day Telephone* _____ Eve Telephone _____ Mobile _____

Email _____ Social Security* # _____ - _____ - _____

Driver License # _____ State _____ Other I.D. Type _____ Number _____

Dependents (Spouse, Children up to the age of 25, Parents in household over age 60 and other IRS Dependents)				
Name (First, M.I., Last)*	Sex* (M/F)	Date of Birth* MM/DD/YYYY	Identification Number*	Relationship*
		/ /		
		/ /		
		/ /		
		/ /		

Attach separate sheet for additional dependents

Section 2: Program Information

** Required Information*

Plan Type *	Select One	One time Registration Fee	Monthly Fee	Whealthcare Deposit**	Total Amount at Time of Enrollment
Individual	<input type="checkbox"/>	\$10	\$10	\$250	\$270
2-Person	<input type="checkbox"/>	\$20	\$20	\$250	\$290
Family	<input type="checkbox"/>	\$30	\$30	\$250	\$310

*All Plans include Physicians, Pharmacy, Dental, Vision, 24-hr hotline, Alternative care, Global Medical Access, 24-hr health visits records, Free Yoga classes and many other WhealthCare Services for an individual.

Minimum WhealthCare deposit an is \$250. The one time registration fee is one time charge. The WhealthCare deposits will be held under the primary member's name at the First American Bank of Elk Grove, Illinois. **These funds can only be used for healthcare services.

All new members must read and sign below. I understand that the WhealthCare is not an insurance program. WhealthCare plan offers savings to self pay customers on their healthcare services. I understand that in order to receive the full benefits and savings, I must access WhealthCare provider's network. I am fully responsible for paying fees to the service providers that are incurred by me or my dependent(s). SAAGII is not responsible and is not liable for any type of fees incurred by me or my dependent(s).

SAAGII is authorized to deduct first payment and monthly periodic payment from my account as noted below. I agreed to abide by the members Terms and conditions.

Month Day Year

*Primary Member's Signature.....Date...../...../.....

For Office Use: Date received...../...../..... Account Number.....-.....-..... Approved YES NO



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Section 3: Payment Information

** Required Information*

PAYMENT OPTIONS For Monthly Auto Pay, the amount will be deducted from your credit card or checking account each month

Please check one option: Individual (monthly) \$10.00 Family (monthly auto pay) 20.00 Family (monthly auto pay) 30.00
 Individual (annual) \$110.00 Family (annual) \$220.00 Family (annual) \$270.00

METHOD OF PAYMENT Choose from Option A, B, or C

A. Bill my debit/Credit Card (check one) Visa American Express MasterCard Discover

Name on Debit/Credit Card: _____

Account Number: _____ Expiration Date: _____

Billing Address (if different from mailing address): _____

B. Bill my Checking Account (include voided check with the application)

Bank/Institution Name: _____ Routing Number: _____

Name of Account Holder: _____ Account Number: _____

C. Check is enclosed for the Annual Rate (please make check payable to SAAGII Inc.)

AUTHORIZATION

I authorize SAAGII, Inc., to bill my credit card or checking account for the program I have selected. This charge shall remain in force until I inform SAAGII, Inc., in writing of its cancellation. I understand the terms and conditions of the program as described on the attached brochure.

X

Applicant Signature

WhealthCare is offered by SAAGII, Inc. DBA SAAGII Administrators, Inc. WhealthCare is not an insurance product. Participation is based on a 12-month period that begins on your first effective day of the program.

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY

Choose the following option that applies:

To begin Check-O-Matic withdrawals:

Select a desired withdrawal day: (1-28): _____

Bank Name _____

City _____ State _____

* **To add this policy to an existing Check-O-Matic:**

Jane Doe	* (Transit Number)	1234
2139 S. 33 Street	Date	
AnyTown, USA 12345		
Pay to the order of _____	\$	<input type="text"/>
_____ Dollars		
ANYTOWN BANK		
Memo _____		
123456789	987654321	1234
(Routing Number)	(Account Number)	(Check Number)

EXAMPLE

Routing & Transit Numbers _____ Account Number _____

**You must either submit a voided check, or complete the routing and account information.
Do not send a deposit slip. Please print clearly.**

For Office Use: Date received...../...../..... Account Number..... Approved **YES NO**