***AAQHC**, An Administrator*
26050 Mureau Road, Sutie 220
Calabasas, California 91302
(818) 591-8700 • FAX (818) 591-8722
(800) 669-8700 • www.aaqhc.com

FOR OFFICIAL USE ONLY

____
Acct.#: ______________________
Group Eff. Date: ________________

GROUP MEMBERSHIP APPLICATION AND GUIDELINES

Full Legal Name: ____

Street Address: ____

City: ____________________ State: ______________ Zip: ________

Telephone: (______) _______ - ___________ Fax: (______) _______ - ___________ Email: ______________

Contact Name: ____________________ Federal ID#: ____________________

Contact Title: ________________ Requested Effective Date (1st of the month only) ______________

We hereby apply for non-voting associate membership in the American Association for Quality Health Care (AAQHC) and participation in the AAQHC benefit programs as owners and employees of the above-named company.

WE UNDERSTAND THAT:

1. Coverage of the various programs may terminate for failure to pay membership dues required by AAQHC, An Administrator.

2. Misrepresentation or omission in answering any part of the application may result in the cancellation of our membership, and we agree to pay for any and all services arising from the misrepresentation or omission.

3. As a member, we will receive the Membership Benefits package and may be eligible for optional programs available through AAQHC.

4. The monthly membership dues are $5.00 per group, plus $1.00 per member to a maximum of $20.00 per account. If a Guardian plan is purchased, membership dues are a total of $10.00 per group, per month.

5. All membership dues are non-refundable.

6. The monthly payment for AAQHC membership and any optional benefits must be received in the office of AAQHC, An Administrator, by the 15th of the month preceding the benefit period. Failure to make the monthly payment may cause all AAQHC benefits to terminate. Charges to reinstate will be assessed at a rate equal to 5% with a minimum of $5.00 and a maximum of $150.00.

7. Returned payments will be assessed a $25.00 service charge and are subject to late charges.

8. We may subsequently terminate our membership with a thirty (30) days' prior written notice to AAQHC, An Administrator, and have no obligation except that which accrued during the time of our membership. If we terminate our membership entirely or if we terminate the dental benefits portion of our membership only, we acknowledge that we will not be eligible to re-apply to AAQHC, An Administrator, for dental benefits for one year from the date of termination.

9. All applications must be received in the office of AAQHC, An Administrator, by the 15th of the month preceding a benefit period (coverage month) in order to be considered for that benefit period.

10. It is the employer's responsibility to keep AAQHC, An Administrator, apprised of any change in status as it affects state or federal laws or regulations.

11. AAQHC, An Administrator, reserves the right to deny any application.

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12. AAQHC, An Administrator, has the authority to execute all policies and agreements with providers chosen to provide benefits in accordance with any applicable federal and state law.

13. It is understood that AAQHC, An Administrator, and its related entities uses binding arbitration to settle all disputes with its members, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute between AAQHC, An Administrator, and any of its members, including disputes as to medical malpractice, that is as to whether any medical services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute between AAQHC, An Administrator, and its members, including any dispute for medical malpractice, any dispute relating to the delivery of service under the plan, and any claims in tort, contract or otherwise, between AAQHC, An Administrator, and any individual(s) seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be.

MAKE ALL CHECKS AND MONEY ORDERS PAYABLE TO **AAQHC**, **AN ADMINISTRATOR**.

I HAVE READ ALL OF THE CONDITIONS AS STATED IN THIS GROUP MEMBERSHIP APPLICATION & GUIDELINES. I DECLARE THAT I AM FULLY AUTHORIZED TO SIGN THIS GROUP MEMBERSHIP APPLICATION & GUIDELINES ON BEHALF OF THE APPLYING COMPANY AND ITS EMPLOYEES.

______________________________	______________________________
Authorized Company Officer – Please Print	Title
______________________________	______________________________
Signature	Date

BROKER STATEMENT

Broker Name: ______________________________ Broker #: ____________________

Email: ____

Tax ID Number: __________________ – __________ – ____________________

I HAVE REVIEWED AND EXPLAINED TO MY CLIENT ALL OF THE CONDITIONS STATED IN THIS GROUP MEMBERSHIP APPLICATION AND GUIDELINES.

______________________________	______________________________
Signature	Date

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