



**Small Business Application Form  
Best Discount Benefits**  
P. O. Box 4022 Oceanside, CA 92052  
Voice Mail and Fax 1-800-585-2363



Please mark your choice of discount program below:

		Monthly	Annual		Monthly	Annual		Monthly	Annual
<b>Dental-Vision Only</b>	Single	<input type="checkbox"/> \$6.95	<input type="checkbox"/> \$63	Couple	<input type="checkbox"/> \$11.95	<input type="checkbox"/> \$108	Family	<input type="checkbox"/> \$15.95	<input type="checkbox"/> \$144
<b>Multi-Care Plan</b>	Single	<input type="checkbox"/> \$8.95	<input type="checkbox"/> \$81	Couple	<input type="checkbox"/> \$12.95	<input type="checkbox"/> \$117	Family	<input type="checkbox"/> \$16.95	<input type="checkbox"/> \$153
<b>Total-Care Plan</b>	Single	<input type="checkbox"/> \$18.95	<input type="checkbox"/> \$171	Couple	<input type="checkbox"/> \$24.95	<input type="checkbox"/> \$225	Family	<input type="checkbox"/> \$29.95	<input type="checkbox"/> \$269
I request that my plan be effective:		<input type="checkbox"/> 1 <sup>st</sup> of Current Month		<input type="checkbox"/> 1 <sup>st</sup> of Next Month					

**All plans require a one-time \$20 processing fee – Annual plans represent a 25% savings**

Name↑ \_\_\_\_\_ Date \_\_\_\_\_ SB \_\_\_\_\_  
Group \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Area Code Home Phone Work Phone

E-mail address \_\_\_\_\_ Company Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Please charge my monthly payments to:**

Visa  MasterCard  Discover  American Express

Name on Account (If different than above) \_\_\_\_\_

Account # \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

**Please debit my checking account monthly.** Attached is a voided check from the account I want debited for these charges.

I authorize CAREINGTON International to bill my credit card or checking account for the plan I have selected. This charge shall remain in force unless I notify CAREINGTON International in writing of its cancellation. Please note that this is not health insurance and we do not make payments directly to medical services providers. It is a discount program, and you are obligated to pay for all health care services. You will receive discounts for medical services at certain health care providers who have contracted with the plan. This plan is administered by CAREINGTON International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034. The program and its administrators have no liability for providing or guaranteeing service or the quality of service rendered. Note to Utah residents: this contract is not protected by the Utah Life and Health Guaranty Association.

X \_\_\_\_\_  
Signature

**I have enclosed a check for the annual amount made payable to: CAREINGTON International**

This is a company paid benefit or a payroll deduction. My company will attach payment and a Group Report Form.

Office Use Only	Member #	GROUP	AGENT	SSUM #	MKT CODE	EFF DATE
		SB	FFSINC			