ENROLLING IN HEALTH-FLEX

1. Complete the application on the next page remember to check which Health-Flex plan you are applying for.

2. Complete all questions. If this is for family benefits remember to list all family members and their dates of birth.

3. Go to next page titled Payment Authorization. Authorize and select your payment option.

4. For Monthly payments you may use our Auto Bank Draft service. Remember to enclose a copy of a check with the word "void" written across the front. Monthly premiums need to be collected this way as preparing and mailing bills would increase cost that would have to be passed on to you the consumer. With Health-Flex we go the extra to save you on cost.

5. You must send us your first premium. A schedule is attached to the premium selection page.

Mail checks to:

Make sure your social security number is on the front of your check.

Infinity Health Plans
Health-Flex
P.O Box 979
Plainview, NY 11803

6. Within ten days after we receive your application you will receive your health plan. It will contain the following:

(You will receive the items that applies to the plan you select)

APIN Network Directory
Holistic Network Directory
Dentist Network Directory
Instruction and information on the use of your plan
Access to MultiPlan Website Directory
24 hour Nurse Service Id
Medical, Drug & Optical Id cards

INFINITY HEALTH PLANS

HEALTH-FLEX APPLICATION (NON GROUP)

PLAN: [ ] DDS [ ] 55 [ ] 365

Name:_____ Social Sec#:_____
DOB:_____

Home Address:_____ City:_____State:___
Zip:_____

Billing Address:_____City:_____State:___
Zip:_____

Telephone Day:_____ Evening_____

Who will be covered?: [ ]Myself Only [ ]Myself and Family Date you want coverage to start: _____

If this is a family plan complete this section for each covered person in the family:

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship
_____	_____	__self_____	_____	_____	_____
_____	_____	__spouse __	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I hereby make application to participate in the discount program offered by Infinity Administrators, Inc. This program will provide me with networks of physicians and other medical care professionals that I may access at discounted fee arrangement as long as I pay as agreed. Should I lapse payment, access to the networks will be denied. I further understand that the cost of services through the networks will be paid by me at time of service, or in some cases when billed. Failure to pay at time of service (or within 25 days of billing) will forfeit my right to the discounted fee schedule and I will be liable for the doctors (or others) regular fee schedule. I understand that Infinity does not provide medical advice nor are they responsible for advice given by any practitioners of medical services in any network. The discount network does not constitute any insurance contract or insurance arrangement. Infinity Administrators, Inc. can be reached at 631-424-2400. After receipt of your application it will take 10 working days to receive your ID cards, manuals and instructions for use of your new medical access plan. When you receive your information kit the plan is in effect immediately unless you requested otherwise. I have read the statements herein and understand them. I sign my name and agree to the terms and conditions of the plan, and I agree to abide by the rules of the plan now in effect or as amended by the Administrator and network providers.

Signed This _____ day of _____ , 20____

BY: **X**_____
Signature of Participant

Broker use only

Code:

Signature:

PAYMENT AUTHORIZATION

Method fo Payment:	[ ]Annual	[ ]Quarterly	[ ]Monthly (billed)	[ ]Monthly (Automatic Bank Draft)
HF-DDSIND	$ 125.00	$ 31.25 N/A	N/A	
HF-DDS FAM	$ 255.00	$ 65.00 N/A	N/A	
HF-55 IND	$ 230.00	$ 58.00	N/A	$ 19.95
HF-55 FAM	$ 410.00	$104.00	N/A	$ 34.95
HF-365 IND	$ 350.00	$ 89.00	N/A	$ 29.95
HF-365 FAM	$ 825.00	$208.00	N/A	$ 69.95

I authorize Infinity Administrators, Inc. to initiate withdrawals from my account at the financial institution named below. Infinity is authorized to make monthly payments on my behalf for the obligation as indicated herein. This authorization will remain valid until Infinity Administrators, my financial institution, or I revoke it. I will submit a void check for the purposes of retaining account information on file. If I change my account I will have to submit a new authorization. I can revoke this authorization by notifying Infinity Administrators, inc., in writing, anytime prior to the 15th of the month payment is scheduled to be deducted from my account. I understand that the "Direct Payment" program is an alternative method of payment only, and does not otherwise affect my rights or the rights of Infinity Administrators, Inc., or my financial institution with respect to each other. I further understand that Infinity Administrators, Inc. And my financial institution reserve the right tp terminate the "direct Payment plan and/or my participation in it. Payments will be withdrawn on the 20th of the month prior to the due date.

Name of Financial Institution._____

X_____ _____

Authorized account holder Signature (Date) Joint account holder Signature (Date)

IMPORTANT.....INCLUDE A COPY OF A VOIDED CHECK

For all plans except Health-Flex 2000 stop here and Mail with your first premium to:

Infinity Health Plans
Health-Flex
P.O Box 979
Plainview, NY 11803