

# BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD N., ST. PETERSBURG, FLORIDA 33716  
NETWORK ACCESS CARD APPLICATION



A subsidiary of Bankers Financial Corporation

The Network Access Card provides a discount to Prescription Benefits and Medical Services received through your Bankers Health Limited Benefit Medical Plan. The Card does not provide Plan Benefits or Covered Services.

## COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Applicant Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## COMPLETE THE FOLLOWING FOR YOUR SPOUSE AND/OR CHILDREN:

Spouse Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security Number \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security Number \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security Number \_\_\_\_\_

## COMPLETE THE FOLLOWING PLAN CHOICES:

<input type="checkbox"/> <b>Option 1:</b> Individual \$10.00	<input type="checkbox"/> <b>Option 2:</b> Individual + 1 \$13.00	<input type="checkbox"/> <b>Option 3:</b> Individual + 2 \$16.00	<input type="checkbox"/> <b>Option 4:</b> Individual + 3 \$19.00	<input type="checkbox"/> <b>Option 5:</b> Individual + 4 \$22.00
<b>Payment Method:</b>	<input type="checkbox"/> <b>Check or Money Order</b>	<input type="checkbox"/> <b>Credit Card</b>	<input type="checkbox"/> <b>Monthly Automatic Bank Withdrawal</b> (Must complete Authorization Form)	

## Agreement:

I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy. **Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony in the third degree.**

I (We) hereby declare the application was signed and dated at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ 20\_\_\_\_  
City/State Month/Day

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

## HOME OFFICE USE ONLY:

Option #/Rate: \_\_\_\_\_ / \_\_\_\_\_

Reviewed: \_\_\_\_\_