AMERICAN ISRAEL MEDI-PLAN MEMBERSHIP APPLICATION

2014

YES, I have read the literature describing the **new** ***AIM PLATINUM Plan*** and also the ***AIM Gold Plan***. Please enroll my son/daughter in the following plan:

☐ The ***AIM PLATINUM Plan*** providing Expanded Medical Services

☐ The ***AIM GOLD Plan*** Comprehensive Medical Services in Israel.

Last name *First* *Mid.* *Passport number* *Social Security #*

Present school or last school attended *Yeshiva attending in Israel or Address in Israel* *mo day year* *Date of Birth*

Home address *City* *State* *Country* *Zip*

Home Phone *Office Phone* *Fax number* *Mobile Phone* *E-Mail*

** If applicable, enclose a copy of insurance card*

Insurance Carrier *Insurance Address* *Policy number* *Name of Policyholder*

CHECK THE PLAN OF YOUR CHOICE

AIM PLATINUM PLAN

☐ **$595. Before Aug. 1, 2014**

☐ **$650. After Aug. 1, 2014**

☐ **$450. 6 months coverage**

AIM GOLD PLAN

☐ **$495. Before Aug. 1, 2014**

☐ **$550. After Aug. 1, 2014**

☐ **$350. 6 months coverage**

**Coverage is effective 14 days after receipt of the signed application and payment.*

METHOD OF PAYMENT ☐ **VISA/MASTERCARD** ☐ **AMERICAN EXPRESS** ☐ **CHECK ENCLOSED**

CARD NO ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Exp Date** ☐☐ ☐☐

Cardmember Name *Cardmember Billing Address*

Signature of Cardmember *Date*

I have read and agree to the Terms & Conditions. I agree to pay for all other medical and dental services incurred by the above named registrant, which services are not covered by the terms and conditions of this agreement, as billed by AIM within 14 days after billing date, with a late penalty charge of 1 ½% per month on past due balances, according to the accepted formula of Heter Iska.

Signature of Applicant, parent or Guardian responsible *(Please state)* *Date*

Make check payable and mail to: **AMERICAN ISRAEL MEDI-PLAN, Inc.**
20533 Biscayne Blvd. Suite N202, Aventura, FL. 33180

For further information call: **1-800-4-AIM-PLAN** **Fax application to: 305-359-5710**

For office use only ☐ ***Application Signed*** ☐ ***Medical History Enclosed*** ☐ ***Photo Enclosed***

AIM PLATINUM	☐ $650.	☐ $595.	☐ $450.
AIM GOLD	☐ $550.	☐ $495.	☐ $350.

AIM representative *Date application received* *Credit approval #*

Please fill in the information above and mail with the medical history form, photo and check or credit card payment. This application is for a full years medical coverage. If for any reason your son/daughter does not come to Israel, you will receive a complete refund.

This coverage is provided in accordance with the Terms & Conditions on the published website < www.aim.co.il. > and the Master Agreement which is also available upon request at any time, by contacting the AIM Administrator at info@aim.co.il.

AIM OFFICE COPY