



# ENROLLMENT PROCESS

For agent use only. Not for distribution to customers.



# ENROLLMENT PROCESS

Agent walkthrough

Customer walkthrough



# AGENT WALKTHROUGH



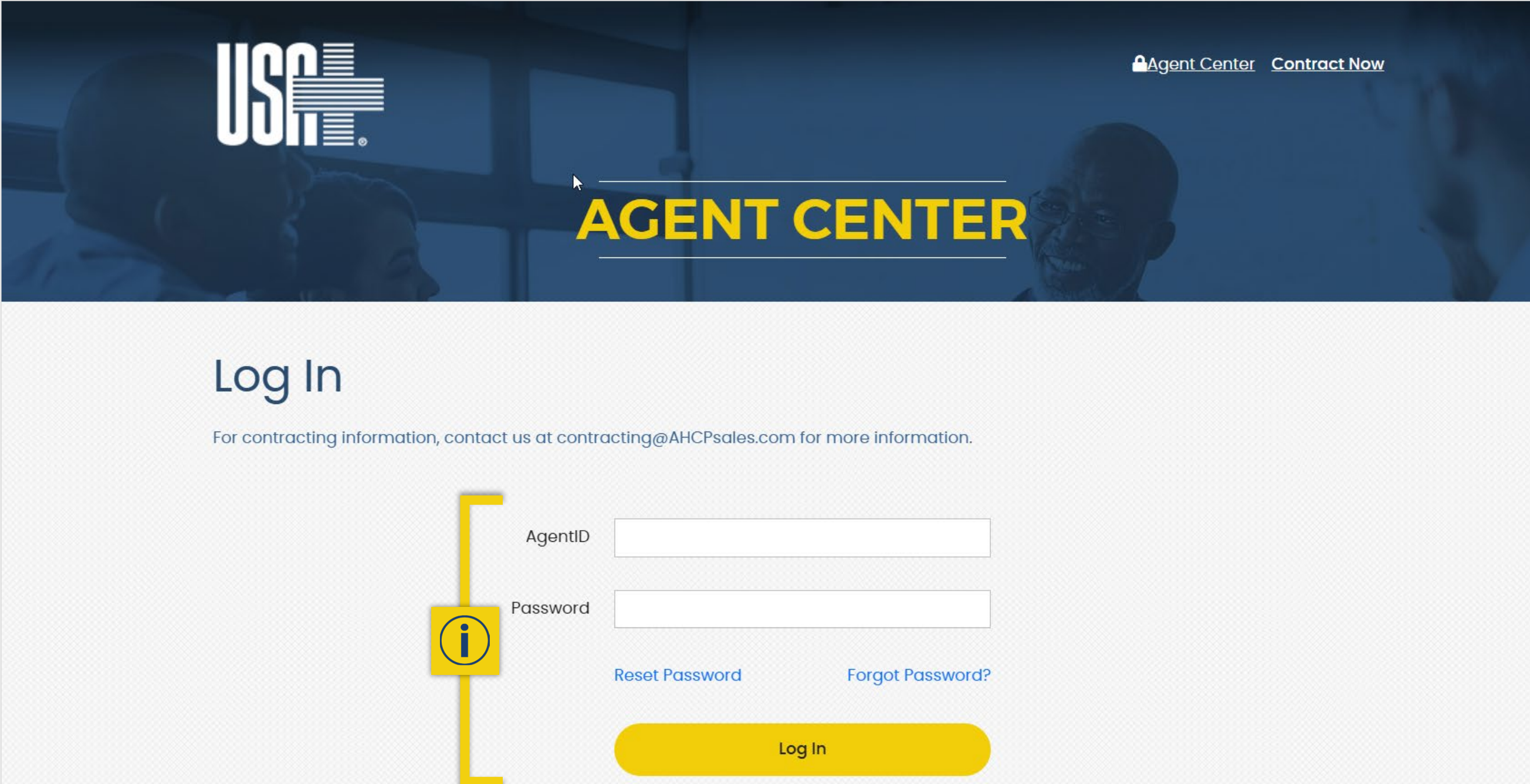

# Agent Walkthrough

- Navigate to <https://ahcpagents.usahc.com>.
- Click on **Agent Center**.



# Agent Walkthrough

- Enter AgentID and Password to log in to Agent Center.




USP

[Agent Center](#) [Contract Now](#)

## AGENT CENTER

### Log In

For contracting information, contact us at [contracting@AHCPsales.com](mailto:contracting@AHCPsales.com) for more information.

 AgentID

Password

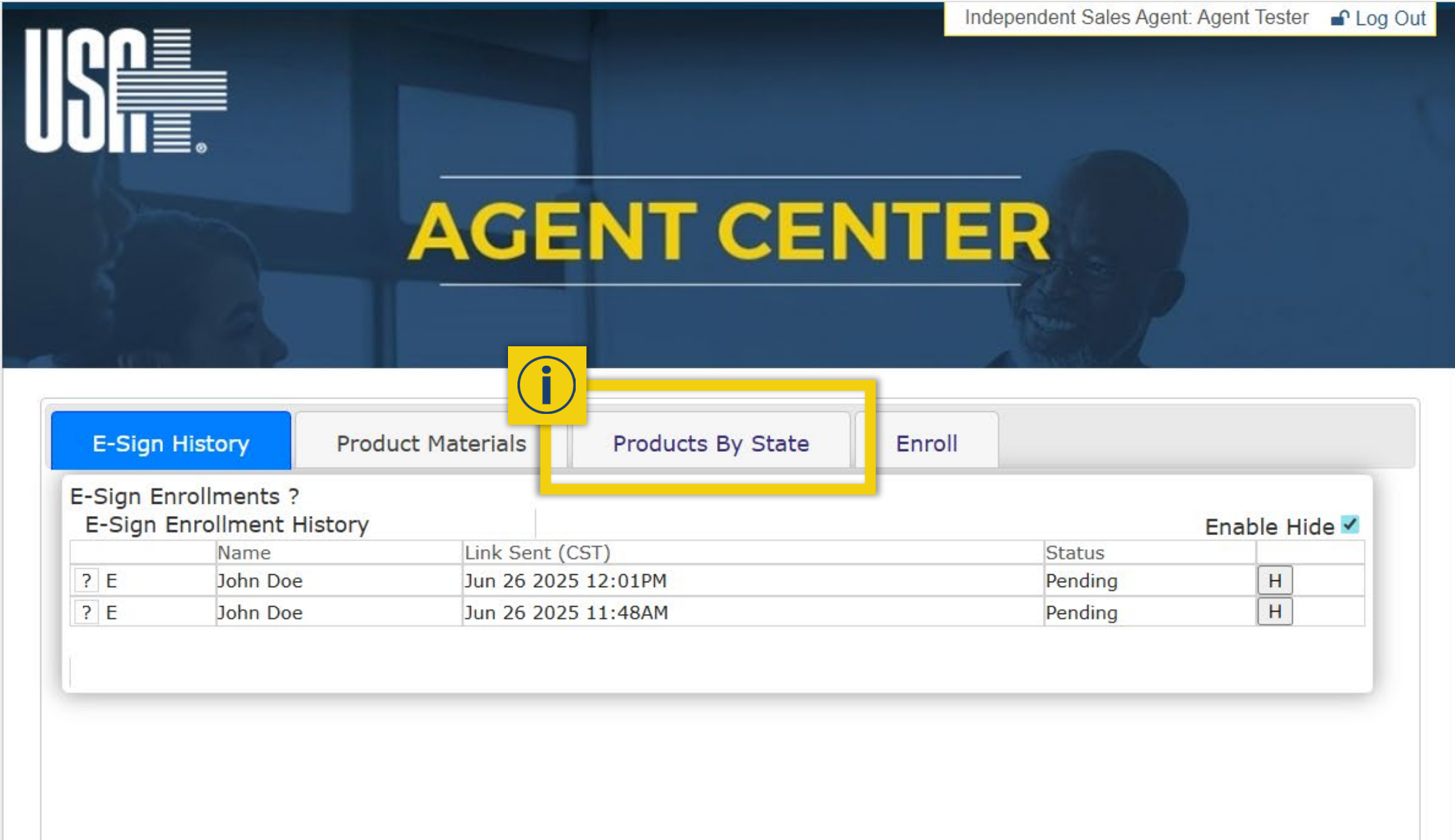
[Reset Password](#) [Forgot Password?](#)

[Log In](#)



# Agent Walkthrough

- On the Home Screen, click on **Products By State**.



Independent Sales Agent: Agent Tester [Log Out](#)

## AGENT CENTER

**Products By State**

E-Sign Enrollments ?  
E-Sign Enrollment History

	Name	Link Sent (CST)	Status	Enable Hide <input checked="" type="checkbox"/>
? E	John Doe	Jun 26 2025 12:01PM	Pending	H
? E	John Doe	Jun 26 2025 11:48AM	Pending	H

# Agent Walkthrough

- Select customer's resident state from drop-down menu.

Independent Sales Agent: Agent Tester [Log Out](#)

[Agent Center](#) [Contract Now](#)

**USR**

Please select a state

**i** Please select

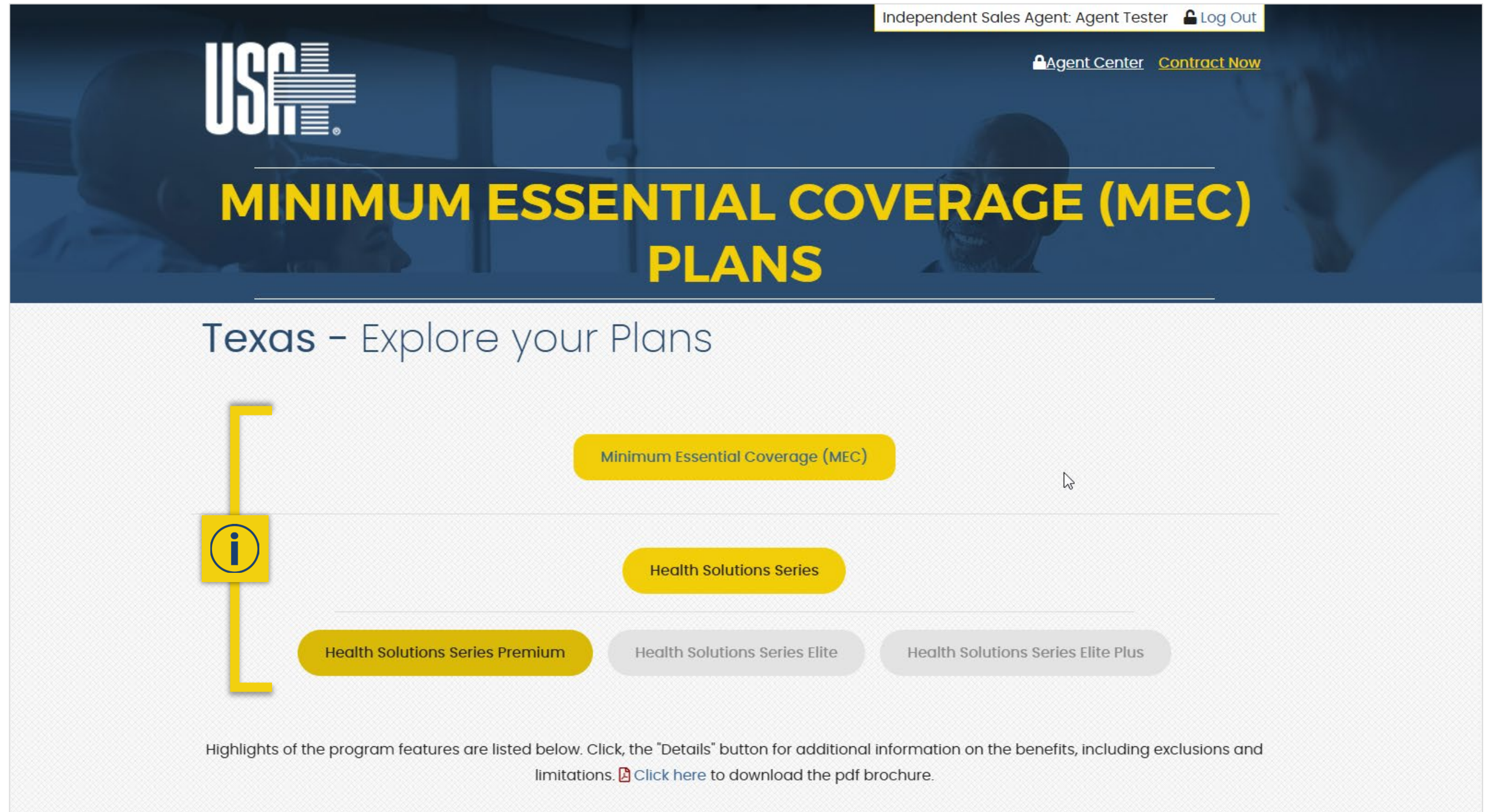


A map of the United States with state abbreviations labeled. The states shown are: WA, OR, ID, MT, ND, MN, WI, MI, NY, VT, NH, ME, MA, RI, CT, NJ, DE, MD, DC, PA, OH, WV, VA, NC, SC, GA, FL, AL, MS, AR, OK, NM, AZ, UT, CO, KS, MO, IL, IN, KY, TN, TX, LA, AK, and HI.



# Agent Walkthrough

- Click on the desired plan and plan level to select.



The screenshot shows the USA+ website interface for Texas. At the top, the USA+ logo is on the left, and the text "Independent Sales Agent: Agent Tester" with a "Log Out" link is on the right. Below the logo, the text "Agent Center" and "Contract Now" are visible. The main heading is "MINIMUM ESSENTIAL COVERAGE (MEC) PLANS". Below this, it says "Texas - Explore your Plans". A yellow bracket on the left side of the plan list is labeled with an "i" icon. The plan list includes "Minimum Essential Coverage (MEC)", "Health Solutions Series", "Health Solutions Series Premium", "Health Solutions Series Elite", and "Health Solutions Series Elite Plus". At the bottom, a note states: "Highlights of the program features are listed below. Click, the 'Details' button for additional information on the benefits, including exclusions and limitations. [Click here](#) to download the pdf brochure."

Independent Sales Agent: Agent Tester [Log Out](#)

[Agent Center](#) [Contract Now](#)

## MINIMUM ESSENTIAL COVERAGE (MEC) PLANS

### Texas - Explore your Plans

**i**

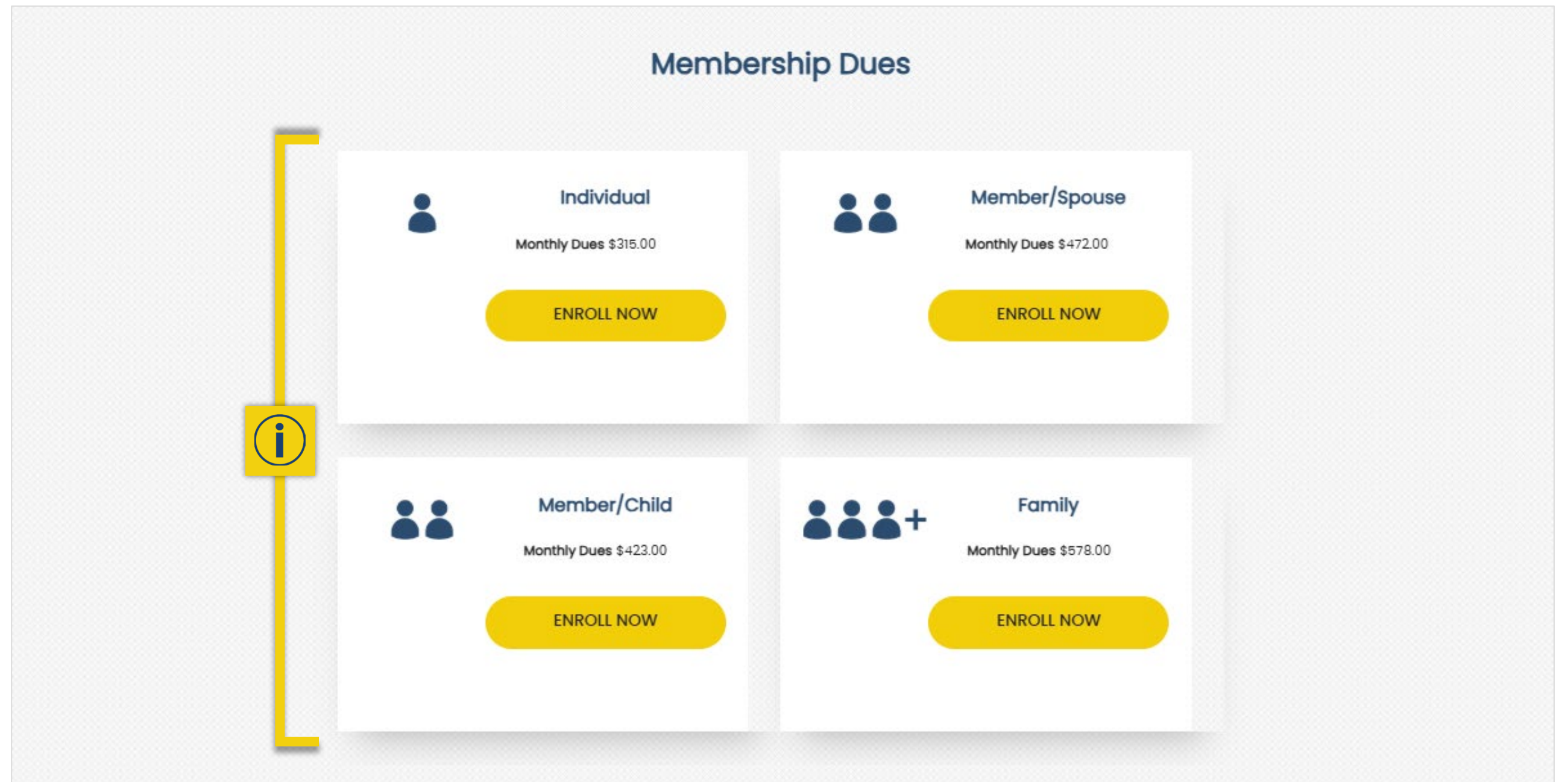
- Minimum Essential Coverage (MEC)
- Health Solutions Series
- Health Solutions Series Premium
- Health Solutions Series Elite
- Health Solutions Series Elite Plus

Highlights of the program features are listed below. Click, the "Details" button for additional information on the benefits, including exclusions and limitations. [Click here](#) to download the pdf brochure.



# Agent Walkthrough

- Under Membership Dues, click on **Enroll Now** to select who is going to be insured and begin enrollment process.



# Agent Walkthrough

- Enter the required information on the enrollment application.
- Click on **Continue Enrollment**.

Please fill out as much information as possible and continue to product selection

**Personal Information**

**Enrollment Agreement Type**  
☐ For Administrative Use Only  
☒ e-Signature agreement link sent to customer via email

**Personal Information**

<b>First Name *</b>	<b>MI</b>	<b>Last Name *</b>	<b>Suffix</b>
<input type="text" value="First Name"/>	<input type="text" value="Middle Initial"/>	<input type="text" value="Last Name"/>	<input type="text"/>
<b>Gender *</b>	<b>Date of Birth *</b>	<b>Primary Phone *</b>	<b>Secondary Phone</b>
<input type="text" value="Select"/>	<input type="text" value="Date of Birth"/>	<input type="text" value="Primary Phone"/>	<input type="text" value="Secondary Phone"/>
<b>Email Address *</b>	<b>Verify Email Address *</b>	<b>Preferred Language</b>	
<input type="text" value="Email Address"/>	<input type="text" value="Verify Email Address"/>	<input type="text" value="English"/>	

**Resident Address**

<b>Street Address *</b>	<b>Apartment/Suite</b>	<b>City *</b>	<b>State *</b>
<input type="text" value="Street Address"/>	<input type="text" value="Apartment/Suite"/>	<input type="text" value="City"/>	<input type="text" value="Select"/>
<b>Zip/Postal Code *</b>			
<input type="text" value="Zip/Postal Code"/>			

**Mailing Address**  
☐ Same as resident address

<b>Street Address *</b>	<b>Apartment/Suite</b>	<b>City *</b>	<b>State *</b>
<input type="text" value="Street Address"/>	<input type="text" value="Apartment/Suite"/>	<input type="text" value="City"/>	<input type="text" value="Select"/>
<b>Zip/Postal Code *</b>			
<input type="text" value="Zip/Postal Code"/>			

\*The mailing address will be used when shipping the membership welcome kit.

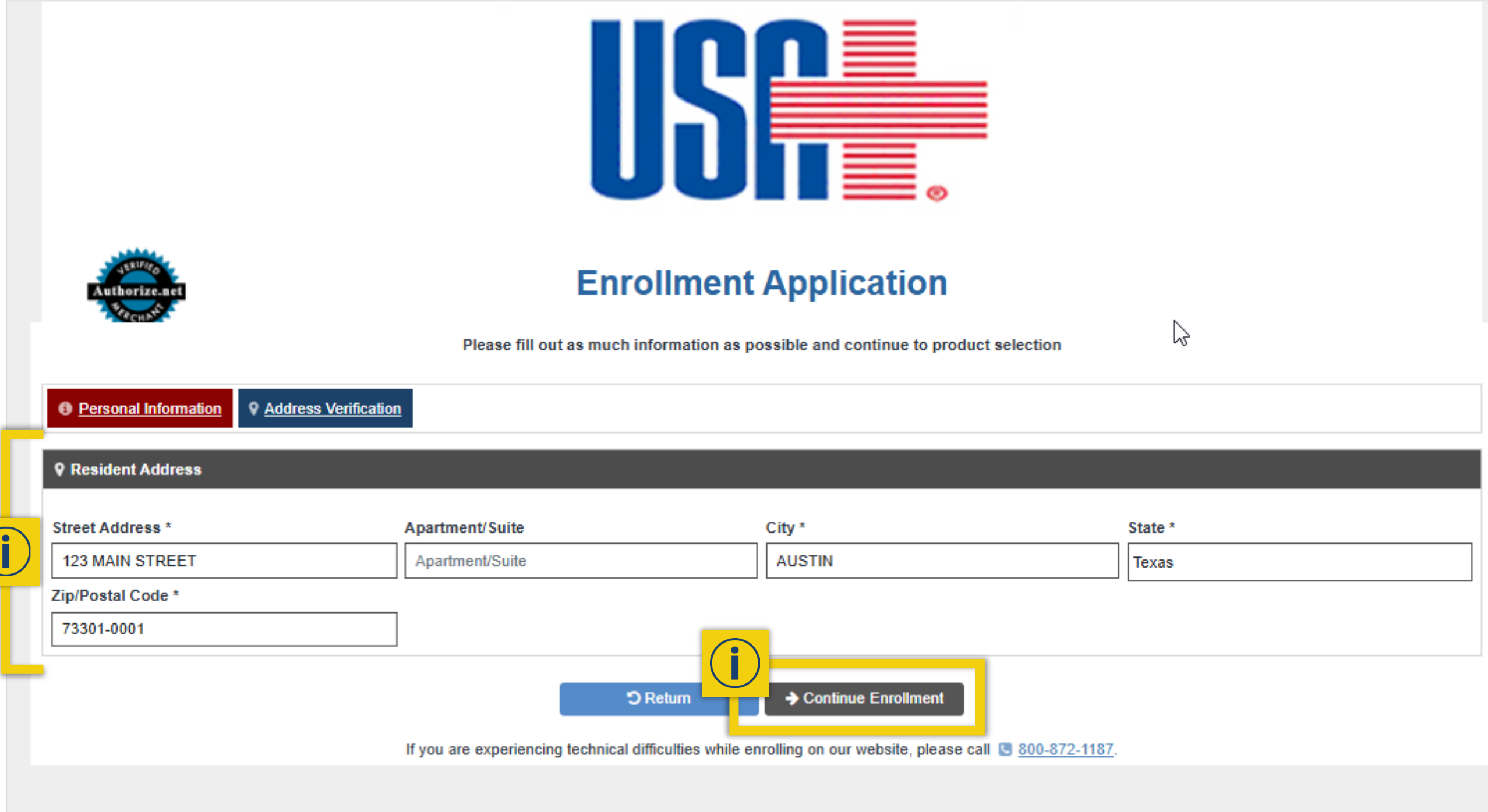

**Continue Enrollment**





# Agent Walkthrough

- Verify customer's residential mailing address is correct.
- Click on **Continue Enrollment**.



The image shows a screenshot of the USA+ Enrollment Application form. The form is titled "USA+ Enrollment Application" and includes a "Verified Merchant" badge. The instructions state: "Please fill out as much information as possible and continue to product selection". The form has two tabs: "Personal Information" and "Address Verification". The "Address Verification" tab is active, showing the "Resident Address" section. The form fields are: Street Address \* (123 MAIN STREET), Apartment/Suite (Apartment/Suite), City \* (AUSTIN), State \* (Texas), and Zip/Postal Code \* (73301-0001). The "Continue Enrollment" button is highlighted with a yellow box and an information icon. The "Return" button is also visible. A footer note states: "If you are experiencing technical difficulties while enrolling on our website, please call 800-872-1187."

**USA+**

**Enrollment Application**

Please fill out as much information as possible and continue to product selection

**Personal Information** **Address Verification**

**Resident Address**

Street Address \*  
123 MAIN STREET

Apartment/Suite  
Apartment/Suite

City \*  
AUSTIN

State \*  
Texas

Zip/Postal Code \*  
73301-0001

**Return** **Continue Enrollment**

If you are experiencing technical difficulties while enrolling on our website, please call 800-872-1187.

# Agent Walkthrough

- Click on appropriate membership to begin enrollment process.
- Click on **Continue Enrollment**.

Welcome to United Service Association For Health Care



Enrollment Application



 Select a Membership for Enrollment



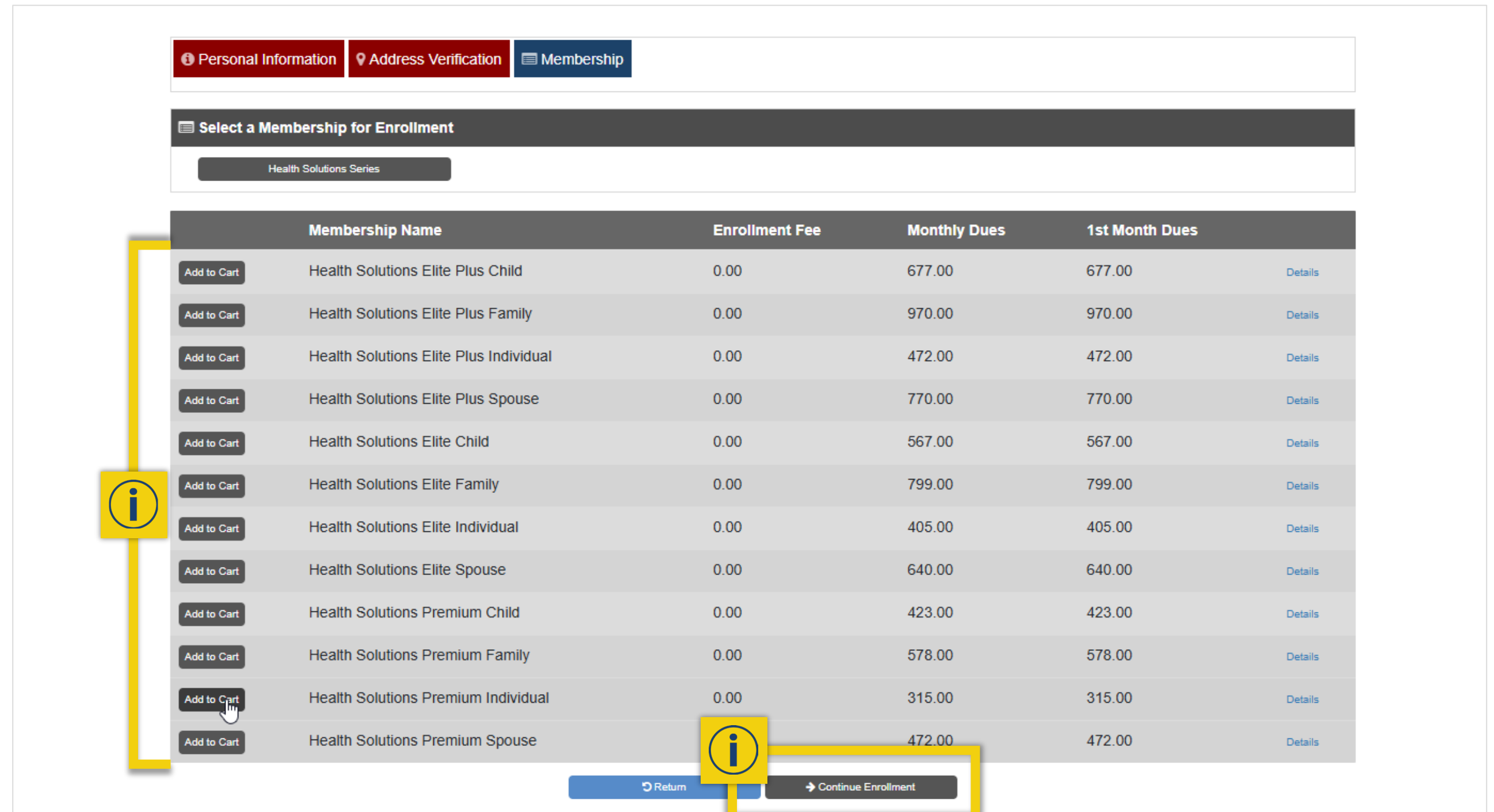
 

If you are experiencing technical difficulties while enrolling on our website, please call  800-872-1187.



# Agent Walkthrough

- Click on **Add to Cart** next to selected plan.
- Click on **Continue Enrollment**.



The screenshot shows the 'Membership' tab of the enrollment process. A yellow callout box with an information icon points to the 'Add to Cart' button for the 'Health Solutions Premium Individual' plan. Another yellow callout box with an information icon points to the 'Continue Enrollment' button at the bottom right.

**Personal Information** **Address Verification** **Membership**

**Select a Membership for Enrollment**

Health Solutions Series

	Membership Name	Enrollment Fee	Monthly Dues	1st Month Dues	
<a href="#">Add to Cart</a>	Health Solutions Elite Plus Child	0.00	677.00	677.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Plus Family	0.00	970.00	970.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Plus Individual	0.00	472.00	472.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Plus Spouse	0.00	770.00	770.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Child	0.00	567.00	567.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Family	0.00	799.00	799.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Individual	0.00	405.00	405.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Elite Spouse	0.00	640.00	640.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Premium Child	0.00	423.00	423.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Premium Family	0.00	578.00	578.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Premium Individual	0.00	315.00	315.00	<a href="#">Details</a>
<a href="#">Add to Cart</a>	Health Solutions Premium Spouse		472.00	472.00	<a href="#">Details</a>

[Return](#) [Continue Enrollment](#)

# Agent Walkthrough

- Select the appropriate effective date.
- Click **Ok** to continue.



Personal Information

Address Verification

Membership

Select a Membership for Enrollment

Health Solutions Series

	Membership Name	Enrollment Fee	Monthly Dues	1st Month Dues	
Add to Cart	Health Solutions Elite Plus Child	0.00	677.00	677.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Plus Family	0.00	970.00	970.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Plus Individual			472.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Plus Spouse			770.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Child			567.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Family			799.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Individual			405.00	<a href="#">Details</a>
Add to Cart	Health Solutions Elite Spouse	0.00	640.00	640.00	<a href="#">Details</a>
Add to Cart	Health Solutions Premium Child	0.00	423.00	423.00	<a href="#">Details</a>
Add to Cart	Health Solutions Premium Family	0.00	578.00	578.00	<a href="#">Details</a>
Add to Cart	Health Solutions Premium Individual	0.00	315.00	315.00	<a href="#">Details</a>
Add to Cart	Health Solutions Premium Spouse	0.00	472.00	472.00	<a href="#">Details</a>

Return

Continue Enrollment

Select Effective Date

☐

☐ 7/1/2025

☐ 7/15/2025

☐ 8/1/2025

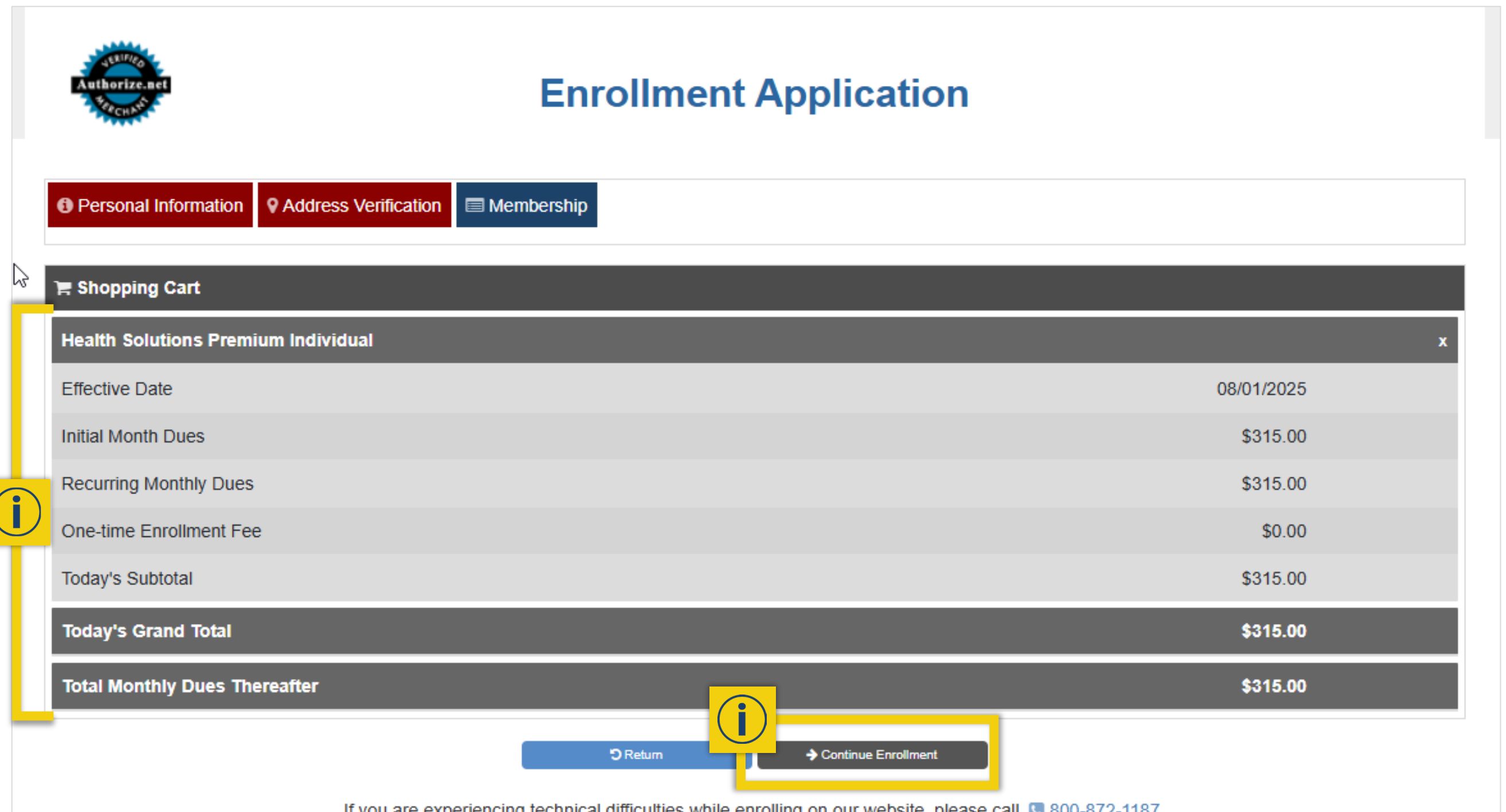
Ok

Cancel



# Agent Walkthrough

- Verify all information shown in cart is correct.
  - Click on **Continue Enrollment**.



**Enrollment Application**

**Shopping Cart**

<b>Health Solutions Premium Individual</b>		<b>x</b>
Effective Date	08/01/2025	
Initial Month Dues	\$315.00	
Recurring Monthly Dues	\$315.00	
One-time Enrollment Fee	\$0.00	
Today's Subtotal	\$315.00	
<b>Today's Grand Total</b>	<b>\$315.00</b>	
<b>Total Monthly Dues Thereafter</b>	<b>\$315.00</b>	

[Return](#) [Continue Enrollment](#)

If you are experiencing technical difficulties while enrolling on our website, please call 800-872-1187

# Agent Walkthrough

- Read agent acknowledgment box, and check box to agree.



Personal InformationAddress VerificationMembershipPaymentSummary

Shopping Cart

Health Solutions Premium Individual

Effective Date	08/01/2025
Initial Month Dues	\$315.00
Recurring Monthly Dues	\$315.00
One-time Enrollment Fee	\$0.00
Today's Subtotal	\$315.00
<b>Today's Grand Total</b>	<b>\$315.00</b>
<b>Total Monthly Dues Thereafter</b>	<b>\$315.00</b>

Your Information

Name	John Doe
Address	123 MAIN STREET
Phone	(555) 555-5555
Email	allison.dobbs@ngic.com
Date of Birth	1/1/1985
Gender	Male

Membership Effective Date

☐ I agree that I have explained to the member, and the member understands and acknowledges, that the first month's dues and applicable enrollment fees are collected on the effective date.

Click on the Submit button one time only.  
It may take a few seconds for your confirmation page to appear.

The customer will receive an email link to an e-signature document to complete the enrollment.

Send E-Signature Link

If you are experiencing technical difficulties while enrolling on our website, please call 800-872-1187



# Agent Walkthrough

- Click on **Send E-Signature Link** to email customer.



Personal InformationAddress VerificationMembershipPaymentSummary

Shopping Cart

Health Solutions Premium Individual

Effective Date	08/01/2025
Initial Month Dues	\$315.00
Recurring Monthly Dues	\$315.00
One-time Enrollment Fee	\$0.00
Today's Subtotal	\$315.00
<b>Today's Grand Total</b>	<b>\$315.00</b>
<b>Total Monthly Dues Thereafter</b>	<b>\$315.00</b>

Your Information

Name	John Doe
Address	123 MAIN STREET
Phone	(555) 555-5555
Email	allison.dobbs@ngic.com
Date of Birth	1/1/1985
Gender	Male

Membership Effective Date

☐ I agree that I have explained to the member, and the member understands and acknowledges, that the first month's dues and applicable enrollment fees are collected on the effective date.

Click on the Submit button one time only.  
It may take a few seconds for your confirmation page to appear.

The customer will receive an email link to an e-signature document to complete the enrollment.



i

→ Send E-Signature Link

If you are experiencing technical difficulties while enrolling on our website, please call 800-872-1187

# Agent Walkthrough

- A highlighted notice will appear above application sections confirming that email was sent.



## Enrollment Application

The pre-enrollment is complete and a link to the e-signature agreement has been sent to the customer.

[Personal Information](#)[Address Verification](#)[Membership](#)[Payment](#)[Summary](#)[E-Signature](#)[Invoice](#)

Invoice

Date	
Name	John Doe
Address	123 MAIN STREET, AUSTIN, TX, 73301-0001

Membership

Health Solutions Premium Individual

MembershipID	56000127
Membership Effective Date	08/01/2025
Initial Payment Date	08/01/2025
Next Payment Date	09/01/2025
Monthly Dues	\$315.00
First Month Dues	\$315.00
Enrollment Fee	\$0.00
Today's Total	\$315.00
Invoice Number	

Grand Total	\$315.00
-------------	----------

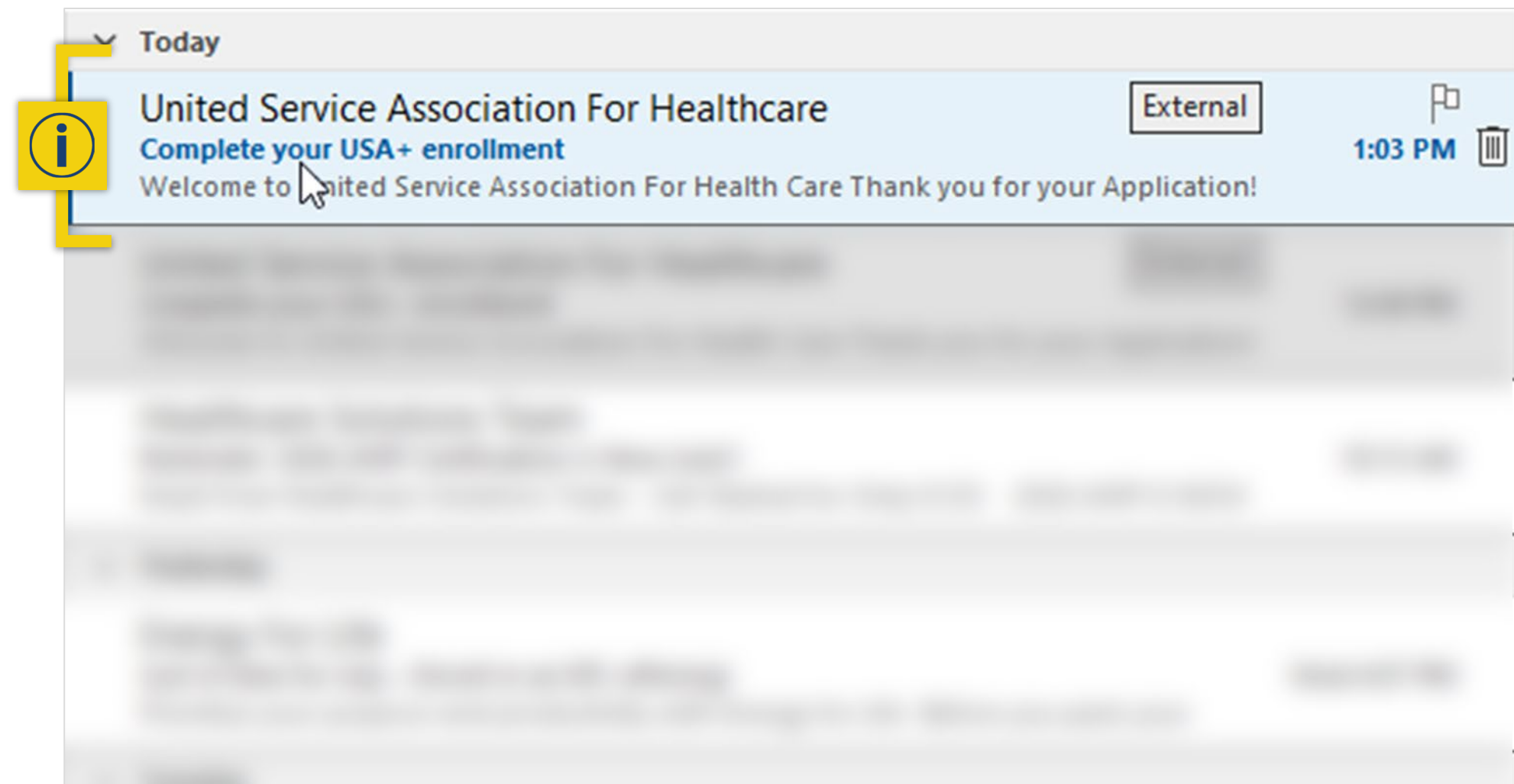
# APPLICANT WALKTHROUGH





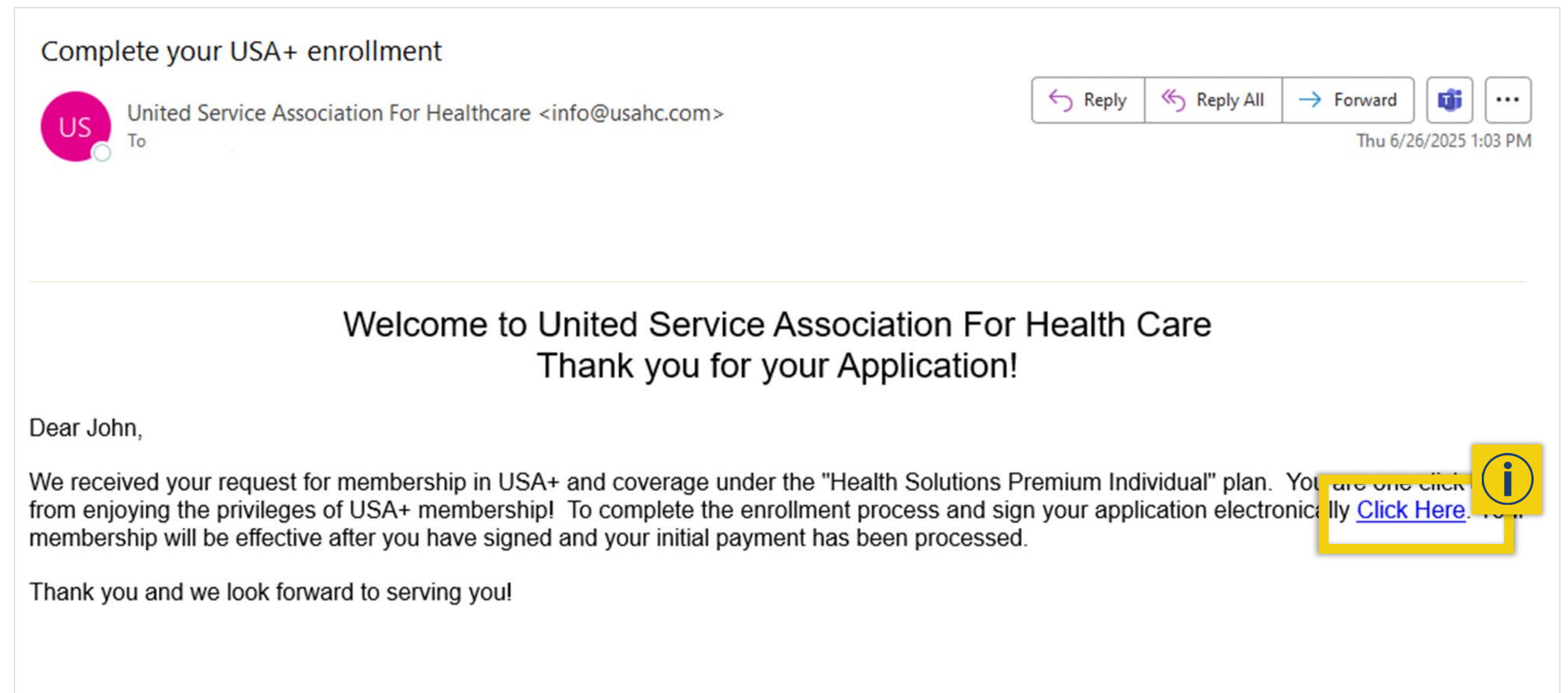
# Applicant Walkthrough

- Customer will receive email with link to complete enrollment.
  - Sender: United Service Association for Healthcare
  - Subject line: “Complete your USA+ enrollment”
- **Note:** If customers do not see email in their inbox, they should check their spam/junk folder.



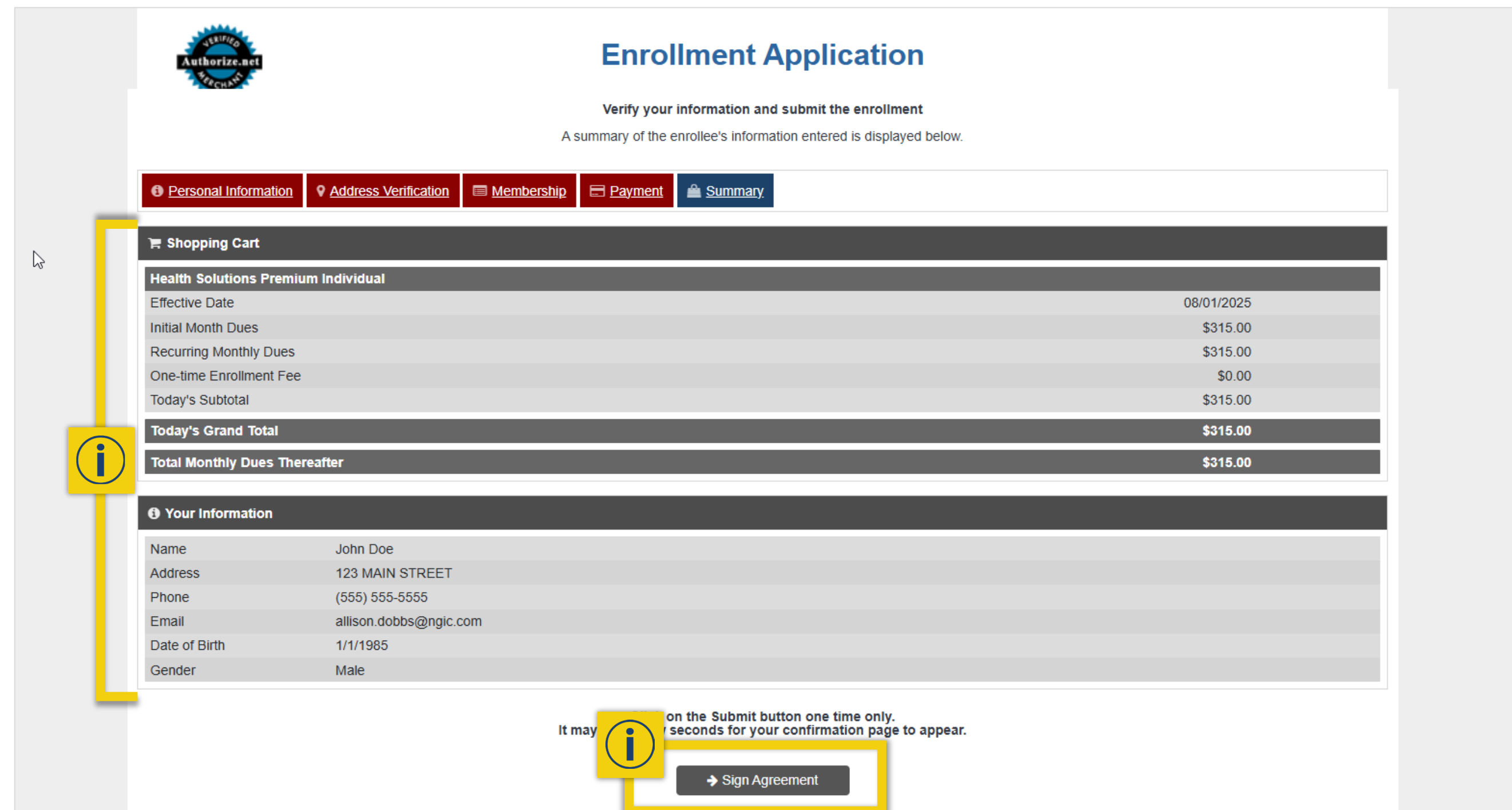

# Applicant Walkthrough

- After opening the email, customer should click on the “Click Here” link to open enrollment application in internet browser.



# Applicant Walkthrough

- Customer should verify all information shown is correct, and then click on **Sign Agreement**.



**Enrollment Application**

Verify your information and submit the enrollment  
A summary of the enrollee's information entered is displayed below.

[Personal Information](#) [Address Verification](#) [Membership](#) [Payment](#) [Summary](#)

**Shopping Cart**

<b>Health Solutions Premium Individual</b>	
Effective Date	08/01/2025
Initial Month Dues	\$315.00
Recurring Monthly Dues	\$315.00
One-time Enrollment Fee	\$0.00
Today's Subtotal	\$315.00
<b>Today's Grand Total</b>	<b>\$315.00</b>
<b>Total Monthly Dues Thereafter</b>	<b>\$315.00</b>

**Your Information**

Name	John Doe
Address	123 MAIN STREET
Phone	(555) 555-5555
Email	allison.dobbs@ngic.com
Date of Birth	1/1/1985
Gender	Male

It may take a few seconds for your confirmation page to appear.


[Sign Agreement](#)



# Applicant Walkthrough

- Customer should read authorizations in full and check all boxes to agree, then click on **Click To Sign**.





## Enrollment Application

[Personal Information](#) [Address Verification](#) [Membership](#) [Payment](#) [Summary](#) [E-Signature](#)

**Health Solutions Elite Individual**

☒ **Submissions via E-Signature:** By enrolling in the Association, I understand and acknowledge that I designate and appoint the Secretary of United Service Association For Health Care (USA+) in office at any particular time and from time to time as my proxy and my agent and attorney-in-fact, to receive all notices of meetings of the members, to attend and vote on the my behalf at any and all meetings of the members, to execute consents and to otherwise act for the me in the same manner and with the same effect as if I were present. I understand and acknowledge that I authorize my proxy and any substitution or revocation with the Association. I further agree that these proxies are voluntary designated appointments and that I have a right to receive all notices of meetings of members and to attend such meetings and vote thereat. In such event, I may notify the Secretary of the Association of my desire in this respect.

☒ **Submissions via E-Signature:** I understand and acknowledge that this membership is subject to the terms and conditions of the Membership Agreement. The Membership Agreement is only applicable for those services received in the United States, except for those exceptions specifically listed in the Membership Handbook. I agree that in order to ensure that I am able to utilize the benefits, it may be necessary for USA+ to send and/or receive personal information about me to the companies that provide products and services to me. I understand that I have 30 days to evaluate the membership and request a full refund. I agree to the purpose of the association, which includes in part promoting equitable public health care policy in the United States, increasing the number of medical providers available to provide medical services, providing education materials that encourage health and financial wellbeing, and assisting charitable, educational and social welfare organizations in the conduct of similar activities.

☒ **Financial Authorization:**  
As a convenience to me, I hereby request and authorize United Service Association For Health Care to charge my account, that I have specifically provided for this purchase, on a monthly basis, or other frequency as requested by me. I certify that I am an authorized user of this credit card or bank account. I agree not to dispute this recurring billing with my bank or card issuer so long as the transactions correspond to the terms indicated in this authorization form. I understand and acknowledge that the first months dues and applicable enrollment fees are collected on the effective date. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such charge and I further agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of membership benefits.

☒ Your ID Cards, Benefit Guide and Certificate of Insurance will be delivered electronically and can be accessed via our website @ [www.usahc.com](http://www.usahc.com), 24 hours a day, 7 days a week. Please review this information as it contains the terms, definitions and exclusions regarding your benefits. You have 30 days to review and evaluate the USA+ membership. If you wish to cancel your membership and receive a full refund, you may do so by submitting a written request or by calling our Member Services Department at 1-800-872-1187 or by submitting a written request to USA+ at 1701 East Lamar Blvd • Suite 185 • Arlington, TX 76006

To submit your application and authorize charges as stated above, please sign your name below:

[Click To Sign](#)

If you are experiencing technical difficulties while enrolling on our website, please call [800-872-1187](tel:800-872-1187).

# Applicant Walkthrough

- Customer should type name in the signature box, and then click on **Click to Sign** to accept signature.



[Personal Information](#) [Address Verification](#) [Membership](#) [Payment](#) [Summary](#) [E-Signature](#)

## Health Solutions Premium Individual

- ☒ **Submissions via E-Signature:** By enrolling in the Association, I understand and acknowledge that I designate and appoint the Secretary of United Service Association For Health Care (USA+) in office at any particular time and from time to time as my proxy and my agent and attorney-in-fact, to receive all notices of meetings of the members, to attend and vote on the my behalf at any and all meetings of the members, to execute consents and to otherwise act for the me in the same manner and with the same effect as if I were present. I understand and acknowledge that I authorize my proxy and any substitution or revocation with the Association. I further agree that these proxies are voluntary designated appointments and that I have a right to receive all notices of meetings of members and to attend such meetings and vote thereat. In such event, I may notify the Secretary of the Association of my desire in this respect.
- ☒ **Submissions via E-Signature:** I understand and acknowledge that this membership is subject to the terms and conditions of the Membership Agreement. The Membership Agreement is only applicable for those services received in the United States, except for those exceptions specifically listed in the Membership Handbook. I agree that in order to ensure that I am able to utilize the benefits, it may be necessary for USA+ to send and/or receive personal information about me to the companies that provide products and services to me. I understand that I have 30 days to evaluate the membership and request a full refund. I agree to the purpose of the association, which includes in part promoting equitable public health care policy in the United States, increasing the number of medical providers available to provide medical services, providing education materials that encourage health and financial wellbeing, and assisting charitable, educational and social welfare organizations in the conduct of similar activities.
- ☒ **Financial Authorization:**  
As a convenience to me, I hereby request and authorize United Service Association For Health Care to charge my account, that I have specifically provided for this purchase, on a monthly basis, or other frequency as requested by me. I certify that I am an authorized user of this credit card or bank account. I agree not to dispute this recurring billing with my bank or card issuer so long as the transactions correspond to the terms indicated in this authorization form. I understand and acknowledge that the first months dues and applicable enrollment fees are collected on the effective date. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such charge and I further agree that if any such charge be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of membership benefits.
- ☒ Your ID Cards, Benefit Guide and Certificate of Insurance will be delivered electronically and can be accessed via our website @ www.usahc.com, 24 hours a day, 7 days a week. Please review this information as it contains the terms, definitions and exclusions regarding your benefits. You have 30 days to review and evaluate the USA+ membership. If you wish to cancel your membership and receive a full refund, you may do so by submitting a written request or by calling our Member Services Department at 1-800-872-1187 or by submitting a written request to USA+ at 1701 East Lamar Blvd • Suite 185 • Arlington, TX 76006

To submit your application and authorize the charges as stated above, please sign your name below:

Print your name

John Doe

Review your signature


Type It Draw It

John Doe

Click to Sign

# Applicant Walkthrough

- Customer should verify billing address shown is correct, and then check box next to desired form of payment.



**Billing Address**

☐ Same as Mailing address

First Name \* Last Name \*

John Doe

Street Address \* Apartment/Suite City \* State \*

123 MAIN STREET Apartment/Suite AUSTIN Texas

Zip/Postal Code \*

73301-0001

Click on Make Payment to proceed to payment for Health Solutions Premium Individual, \$315.00

**Payment Type**

Please select the desired payment method from the two choices below. The amount that will be debited from the account is also displayed. The following payment options are available: American Express, Discover, Mastercard, Visa, or ACH Bank Draft (EFT).

☐ Credit Card ☐ Check

Payments securely processed by:

**Authorize.Net™**  
Where the world does business on the Web

VISA MASTERCARD DISCOVER

Click on the Make Payment button one time only.  
It may take a few seconds for your confirmation page to appear.

© 2025 TeamCorp



# Applicant Walkthrough

- Customer should enter required payment information, and then click on **Make Payment/Pay** to complete enrollment.

**Payment Type**

Please select the desired payment method from the two choices below. The total amount that will be debited from the account is also displayed. The following payment options are available: American Express, Discover, Mastercard, Visa, or ACH Bank Draft (EFT).

☐ Credit Card ☒ Check

<b>Bank Name *</b> Wells Fargo	<b>Name on Account *</b> John Doe	<b>Account Number *</b> 987654321
<b>ABA Routing Number *</b> 123456789	<b>Bank Account Type *</b> Personal Checking	<b>Re-enter Account Number *</b> 987654321

**Bank Name and Address**

My Name 101  
My Address 50-9999/9999 1  
My City, State, & Zip 20  
Pay to the order of \$ Dollars  
The Bank Name  
Bank Address  
123456789 12 34567890 101  
9 Digit Bank Routing Number Your Account Number

Payments securely processed by:

**Authorize.Net™**  
Where the world does business on the Web

VISA AMERICAN EXPRESS Mastercard DISCOVER

Click on the Make Payment button one time only. It may take a few seconds for your confirmation page to appear.

**Make Payment**

**Card Number \***  
VISA 4147 5678 9012 3456

**Exp. Date \***  
01/26

**Card Code \***  
1234


**Pay** **Cancel**

POWERED BY **Authorize.Net**

# Applicant Walkthrough

- Customers will receive plan ID in email after enrollment.



First Health Network

**Limited Benefit Plan**

Group Name:	United Service Association	Deductible: \$2,500 Individual / \$5,000 Family
Plan Name:	Health Solutions Elite	Copay: Preventative \$0   Primary Care \$50   Specialist \$100   Urgent Care \$200
Member Name:	Sample Member Full Name	
Member Number:	012345678	
Coverage Type:	Member & Spouse	
Effective Date:	01/01/2001	

This is a Minimum Essential Coverage (MEC) Plan. Pays 100% of Preventative Services as defined by Centers for Medicare and Medicaid Services (CMS).

**Members:** Please show this card when you or your eligible dependents receive services. If you have any questions regarding claims or prior authorization, please contact (470) 243-2376. If you have any questions regarding benefits, billing, to confirm eligibility or to terminate coverage, please contact 1-800-872-1187. To locate a provider, please visit [www.findvaultproviders.com](http://www.findvaultproviders.com)

## **Card does not guarantee coverage**

Present all patient claims with Member ID and Plan ID number. For questions regarding claims, benefits, prior authorization, or to confirm coverage, please call (470) 243-2376.

To schedule a telehealth appointment, please call 1-844-362-2447.

AMPS Admin Services  
PO Box 2725  
Farmington Hills, MI 48333  
Payer ID: VS402



# QUESTIONS?

- Contact:
  - Agent Support: (877) 228-8773
  - Contracting: [contracting@ahcpsales.com](mailto:contracting@ahcpsales.com)
  - USA+ Customer Service: (800) USA-1187

