Application Form

Questions Call 800-775-3819

How Much Would it Cost You if You Had an Accident?

www.ZaneAMC.com

Protect Your Family from Accidents for < $1 a Day

Pays medical expenses because you have not met your Annual Deductible or Coinsurance, or are away from home (out-of-network).

Includes Dental, Chiropractic, Ambulance & More

Covers Dental, Chiropractic, and hundreds of other items not covered by your health insurance when you have an accident.

Save $2,500 per Year on Your Health Insurance

Save thousands by increasing the Annual Deductible on your Individual or Employer health policy and adding ZaneAMC.

Check Desired Level of Coverage

Accident Medical Coverage[1]	Association Cost/Month Individual[2]	Association Cost/Month Family[2]
$1,000	$9.99 ☐	$19.99 ☐
$2,500	$13.99 ☐	$27.99 ☐
$5,000	$17.99 ☐	$35.99 ☐
$7,500	$19.99 ☐	$39.99 ☐
$10,000	$21.99 ☐	$43.99 ☐

[1]After $100 deductible [2]Plus $25 one-time application fee

NOTICE: Zane Benefits Accident Medical Coverage (AMC) is available only for people who have health insurance (including Medicare). AMC typically covers medical expenses resulting from an accident that are not paid by your health insurance (e.g. Annual Deductible, Coinsurance, Dental, Chiropractic—see website for details). This form is not a solicitation for insurance—by filling out this form you are agreeing to join an Association providing multiple benefits including Accident Medical Coverage under the terms and conditions explained on our website. For more information contact your ZaneAMC Representative.

Complete this form and return or fax to your ZaneAMC Representative: Joshua Harris
136 Heber Avenue Suite 308, Park City Utah, 84060 Phone 800-775-3819 Fax 215-933-1237 info@ZaneAMC.com

Full Name _____ _____
Signature of Cardholder

Address _____ _____
Beneficiary (in case of death of applicant)

City, State, Zip _____

Phone _____ Email _____

VISA or MC# |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| Code |__|__|__|__| Exp (MM/YY) |__|__/__|__|

I/we have Health Insurance from _____
Name of Employer or Health Insurance Carrier