Zane Benefits Accident Medical Coverage

Application Form

Questions Call 800-775-3819

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

www.ZaneAMC.com/Chiro/Donkin

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). This form is not a solicitation for Accident Medical Coverage which can only be obtained by visiting our website. AMC typically covers medical expenses resulting from an accident that are not paid by your health insurance because you have not met your Annual Deductible, Coinsurance, or are away from home, and items not normally covered by health insurance (e.g. Dental, Chiropractic). There are four ways to get Zane Benefits AMC. Prices shown refer to an example of AMC obtained by joining an association which includes other benefits. For more info contact your ZaneAMC Representative.

Complete this form and return or fax to your ZaneAMC Representative: Scott Donkin, DC
5540 South Street, #200 Lincoln, NE 68506 Phone 800-775-3819 Fax 215-933-1237 info@ZaneAMC.com

Full Name _____ _____
Beneficiary (if deceased)

Address _____

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