



**AAQHC, An Administrator**  
 23251 Mulholland Drive  
 Woodland Hills, California 91364-2732  
 (818) 591-8700 • FAX (818) 591-8722  
 (800) 669-8700 • www.aaqhc.com

**FOR OFFICIAL USE ONLY**

Acct.#: \_\_\_\_\_  
 Group Eff. Date: \_\_\_\_\_

**GROUP MEMBERSHIP APPLICATION AND GUIDELINES**

Full Legal Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Federal ID#: \_\_\_\_\_  
 Contact Title: \_\_\_\_\_ Requested Effective Date (1<sup>st</sup> of the month only) \_\_\_\_\_

We hereby apply for non-voting associate membership in the American Association for Quality Health Care (AAQHC) and participation in the AAQHC benefit programs as owners and employees of the above-named company.

**WE UNDERSTAND THAT:**

1. Coverage of the various programs may terminate for failure to pay any of the fees and dues required by AAQHC, An Administrator.
2. Any misrepresentation or omission in answering any part of any application may result in the cancellation of our membership, and we agree to pay for any and all services arising from the misrepresentation or omission.
3. As a member, we will receive the Membership Benefits package and may be eligible for optional programs available through AAQHC.
4. The enrollment fee is \$10.00 per member (one time) with a \$50.00 maximum for any group.
5. The monthly administration fee is \$5.00 per group.
6. The membership dues are \$1.00 per member per month to a maximum of \$15.00 per account, per month.
7. All fees and dues are non-refundable.
8. The monthly payment for AAQHC membership and any optional benefits must be received in the office of AAQHC, An Administrator, by the 15th of the month preceding the benefit period. and failure to make the monthly payment may cause all AAQHC benefits to terminate and/or reinstatement charges to be assessed which are equal to a minimum of \$5.00 or 5% of the premium amount due up to a maximum of \$150.00.
9. Returned checks will be assessed a \$25.00 service charge and are subject to late charges.
10. We may subsequently terminate our membership with a thirty (30) days' prior written notice to AAQHC, An Administrator, and have no obligation except that which accrued during the time of our membership. If we terminate our membership entirely or if we terminate the dental benefits portion of our membership only, we acknowledge that we will not be eligible to re-apply to AAQHC, An Administrator, for dental benefits for one year from the date of termination.
11. All applications must be received in the office of AAQHC, An Administrator, by the 20th of the month preceding a benefit period (coverage month) in order to be considered for that benefit period.

12. It is the employer's responsibility to keep AAQHC, An Administrator, apprised of any change in status as it affects state or federal laws or regulations.
13. AAQHC, An Administrator, reserves the right to deny any application.
14. AAQHC, An Administrator, has the authority to execute all policies and agreements with providers chosen to provide benefits in accordance with any applicable federal and state law.
15. It is understood that AAQHC, An Administrator, and its related entities uses binding arbitration to settle all disputes with its members, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute between AAQHC, An Administrator, and any of its members, including disputes as to medical malpractice, that is as to whether any medical services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between AAQHC, An Administrator, and any individual(s) seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be.

MAKE ALL CHECKS AND MONEY ORDERS PAYABLE TO **AAQHC, AN ADMINISTRATOR**.

**I HAVE READ ALL OF THE CONDITIONS AS STATED IN THIS GROUP MEMBERSHIP APPLICATION & GUIDELINES. I DECLARE THAT I AM FULLY AUTHORIZED TO SIGN THIS GROUP MEMBERSHIP APPLICATION & GUIDELINES ON BEHALF OF THE APPLYING COMPANY AND ITS EMPLOYEES.**

\_\_\_\_\_  
Authorized Company Officer – Please Print

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

AGENT INFORMATION

Agent Name: \_\_\_\_\_ Agent #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ – \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_ – \_\_\_\_\_

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Social Security or ID Number: \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_