# AMERICAN ISRAEL MEDI-PLAN MEMBERSHIP APPLICATION

**WWW.AIM.CO.IL**

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

☐ The ***AIM Gold Plan*** providing FULL MEDICAL SERVICES in Israel.

☐ The ***AIM Basic Plan*** providing BASIC MEDICAL COVERAGE 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 GOLD PLAN***

☐ $470. Before Aug. 1, 2009

☐ $495. After Aug. 1, 2009

***AIM BASIC PLAN***

☐ **$385. Before Aug. 1, 2009**

☐ **$410. After Aug. 1, 2009**

**** 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*

This agreement is valid until Aug.31, 2010.. 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 outstanding 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** **info@aim.co.il** **Fax : 305-792-5472**

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

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

**Please fill in the information above and mail with the medical history form, photo, copy of insurance card and check or credit card payment.**

*** IMPORTANT: Subject to the terms and conditions printed on the back of this form.**
**NOTE: Registration and payment is for a full years medical coverage during the 2009-2010 school year.**
**If for any reason, your son/daughter does not come to Israel, you will receive a complete refund.**

**AIM OFFICE COPY**