



HEALTH ESSENTIAL LIMITED MEDICAL

LIST BILL FORM – MINIMUM OF 2 APPLICATIONS REQUIRED

This is not an employer-sponsored plan: neither the employee nor the employer can treat or represent the premiums as part of an employer-sponsored health insurance program for the purpose of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

Complete the following for a monthly list billing. Please attach Individual Applications, and a check for the first month's premiums/fees due. The effective date is always the first of the month. Payments are due on the same day as selected each month. Premiums must be paid within the plans stated provision for premium payments, or coverage will terminate.

AUTHORIZE BY: _____ COMPANY: _____ Date: _____
 Bill to: _____ Billing Contact Person: _____ Phone: _____
 Billing Address: _____ City: _____ State: _____ Zip: _____

Applicant's First Name (Last, First)*	Plan Basic500, Plus750, Choice1000 or Max1500	Monthly Rates (Applicant, Spouse and dependent children)	Monthly Association & Administration Fee	Enrollment Fee	Total Rates and Fees
			\$12.50	\$25	
			\$12.50	\$25	
			\$12.50	\$25	
			\$12.50	\$25	
			\$12.50	\$25	
			\$12.50	\$25	
			\$12.50	\$25	
			\$12.50	\$25	

**Make Check Payable to:
Mail Applications & Check to:**

**Administrative Concepts, Inc.
Health Insurance Innovations
218 East Bearss Ave, Suite 325
Tampa, Florida 33613
P. 1-877-376-5831
F. 1-877-376-5832**



Agent Name: _____ Company Name: _____
 HII Code: _____ Phone #: _____ Fax #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____