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Primary Phone # (____) _____ cell work home May we text you with important program/subscription information? Yes No (We promise not to sell, rent, or otherwise distribute your information.)

List Covered Device(s)

Make	Model	Serial	Style	Color

CASH CHECK # _____ Credit Card Number _____ Exp ____/____

Type of Card _____ CVV _____ Name on Card _____ ZIP _____

Annual charge \$375

Enrollment may be completed by phone.
 Please call 912.748.9494
 Or in-person at our office.
 You may also enroll by visiting our website:
 www.coastalaudiology.com (click hearing aids>HearWell)
 Or by Mail:
 Coastal Audiology & Hearing Aid Center
 HearWell Program Administrator
 410 SW US HWY 80 Pooler, GA 31322

I understand the discounts and services provided with this program, acknowledge all information is correct. I understand payment for services is due day of enrollment and is non-refundable. I understand that by signing this form I give authorization to charge my credit card for the above referenced enrollment fee. THIS PLAN IS NOT INSURANCE and is not intended to replace insurance. It cannot be combined with any insurance or discount plan. This program is not a Qualified Health Plan under the Affordable Care

Act. By signing below, I agree to comply with and understand all program details as outlined in the program handbook. For further information, please contact: the HearWell Program administrator, Coastal Audiology, 410 SW US HWY 80 Pooler, GA 31322; 912.748.9494 www.coastalaudiology.com

Patient Signature _____ Date _____