

NATIONAL BENEFIT ADVISORY ASSOCIATION

APPLICATION FOR MEMBERSHIP

REQUESTED EFFECTIVE DATE: _____

PLEASE PRINT

	NAME	Date of Birth	Sex	Beneficiary
Primary				
Spouse				
Dep Child				
Dep Child				
Dep Child				
Dep Child				

Billing Address: _____ City: _____

State: _____ Zip: _____ Work Phone: _____ Home Phone: _____ Email: _____

Membership Plan

- | | | | |
|--|--|--|--|
| <input type="radio"/> Diamond Plus Membership | <input type="radio"/> Member Only - \$179.95 | <input type="radio"/> Member +1 - \$209.95 | <input type="radio"/> Member/Family - \$229.95 |
| <input type="radio"/> Diamond Membership | <input type="radio"/> Member Only - \$169.95 | <input type="radio"/> Member +1 - \$189.95 | <input type="radio"/> Member/Family - \$209.95 |
| <input type="radio"/> Platinum Plus Membership | <input type="radio"/> Member Only - \$159.95 | <input type="radio"/> Member +1 - \$189.95 | <input type="radio"/> Member/Family - \$209.95 |
| <input type="radio"/> Platinum Membership | <input type="radio"/> Member Only - \$149.95 | <input type="radio"/> Member +1 - \$169.95 | <input type="radio"/> Member/Family - \$189.95 |
| <input type="radio"/> Gold Membership | <input type="radio"/> Member Only - \$129.95 | <input type="radio"/> Member +1 - \$144.95 | <input type="radio"/> Member/Family - \$159.95 |
| <input type="radio"/> Bronze | <input type="radio"/> Member Only - \$ 99.95 | <input type="radio"/> Member +1 - \$114.95 | <input type="radio"/> Member/Family - \$129.95 |

DUES: \$ _____

ONE-TIME MEMBERSHIP PROCESSING FEE

TEXAS (\$60.00) / ARKANSAS (\$30.00)

ALL OTHER STATES (\$100.00)

\$ _____

TOTAL AMOUNT DUE

\$ _____

Payment Modes (Check One):

- | | |
|---|--|
| <input type="radio"/> Monthly Bank Draft | <input type="radio"/> Quarterly Direct Bill (MBD x 3.00) |
| <input type="radio"/> Monthly Credit Card | <input type="radio"/> Semi-annual Direct Bill (MBD x 6.00) |
| <input type="radio"/> Monthly List Bill (2 or more) | <input type="radio"/> Annual Direct Bill |

I hereby apply for membership in the National Benefit Advisory Association (Association), and by becoming a member of the Association, I understand that I am entitled to certain benefits and services made available through the Association for its members and that dues are required to be paid in order to maintain my membership in the Association.

By signing this application for membership, I fully understand that this is not health insurance nor is this a replacement of health insurance.

Applicant's Signature: _____ SSN: _____ Date: _____

I hereby designate and appoint the Secretary of the National Benefit Advisory Association (Association) in office at any particular time and from time to time as my proxy and my agent and attorney-in-fact to receive all notices of meetings of the members of the Association, to attend and vote on my behalf at any and all meetings of the members of Association, to execute consents and to otherwise act for me in the same manner and with the same effect as if I were personally present. I authorize my proxy to substitute any other person to act under this proxy, to revoke any substitution, and to file this proxy and any substitution or revocation with the Association. I understand that this proxy is a voluntary designated appointment and that I have a right to receive all notices of meetings of members and to attend such meetings and vote thereat. In such event, I will notify the Secretary of the Association of my desires in this respect.

Applicant's Signature: _____ Date: _____ Rep. Name: _____ Rep. Number: _____

AUTHORIZATION TO INITIATE ELECTRONIC DEBITS

As a convenience to me, I hereby request and authorize the National Benefit Advisory Association (Association) to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my account set forth below, for the purpose of debiting membership dues for the Association. I hereby further authorize and request the financial institution to honor debit entries initiated by the Association and debit such account. This authority is to remain in effect until the Association and the financial institution have received a written notification from me of its termination in such time as to afford the Association and the financial institution a reasonable opportunity to act upon it.

I further agree that if any such debit entry is dishonored, whether with or without cause and whether intentionally or inadvertently, the Association shall have no liability whatsoever even though such dishonor results in the termination of my membership in the Association.

- Checking Savings Draft Date: 1st 15th (Circle one)

Financial Institution: _____ Card Type: MC VISA AMEX DISCOVER

City: _____ State: _____ Cardholder Name: _____

ABA/Routing Number: _____ Account Number: _____

Account Number: _____ Expiration Date: _____

Authorized Signature: _____ Date: _____

National Benefit Advisory Association P.O. Box 100877 Fort Worth, Texas 76185-0877 Telephone: 1-877-202-7574 Fax: 1-800-454-3297

By Signing This Application For Membership, I Fully Understand This Is Not Health Insurance Nor Is This A Replacement Of Health Insurance. (See Other Side)

National Benefit Advisory Association (“NBAA”) is not a licensed insurer, health maintenance organization, or other underwriter of health care services. No portion of any provider’s fees will be reimbursed or otherwise paid by NBAA. NBAA is not licensed to provide and does not provide medical services or items to individuals. You will receive discounts for medical services at certain health care providers who have contracted with the plan. You are obligated to pay for all health care services at the time of your appointment. Savings are based upon the provider’s usual and customary fee. Actual savings will vary depending upon location and specific services or products purchased. Please verify such services with each individual provider. The discounts contained herein may not be used in conjunction with any other discount plan or program. All listed or quoted prices are current prices and subject to change without notice. Any procedures performed by a non-participating provider are not discounted. From time to time, certain providers may offer products or services to the general public at prices lower than the discounted prices available through this program. In such event, members will be charged the lowest price. This plan does not discount all procedures. Providers are subject to change without notice and services may vary in some states. It is the member’s responsibility to verify that the provider is a participant in the plan. At any time NBAA or its provider have the right to eliminate a Participating Professional from the respective network in which they are associated and may substitute Provider Networks at its sole discretion. NBAA cannot guarantee the continued participation of any provider nor can NBAA guarantee or warrant the quality or accessibility of services or goods delivered by the respective providers to the members. If the provider leaves the plan, you will need to select another provider. Providers contracted by NBAA are solely responsible for the professional advice and treatment rendered to members and NBAA disclaims any liability with respect to such matters. Services and service providers may change or be discontinued at anytime without notice.

Complaint Procedure: If you would like to file a complaint or grievance regarding your plan membership, you must submit your grievance in writing to: Member Services, NBAA at P.O. Box 100877, Fort Worth, Texas 76185-0877.

Disclosure:

- 1) This plan is not a health insurance policy.
- 2) This plan provides discounts at certain healthcare providers for medical services.
- 3) This plan does not make payments directly to providers of medical services.
- 4) The plan member is obligated to pay for all healthcare services but will receive a discount from those healthcare providers who have contracted with the discount medical plan organization.
- 5) National Benefit Advisory Association, the discount medical plan organization, is located at 4704 Highway 377 South, Fort Worth, Texas 76116.

National Benefit Advisory Association P.O. Box 100877 Fort Worth, Texas 76185- 0877
Telephone: 1-877-202-7574 Fax: 1-800-454- 3297

You will soon receive a Membership Guide which contains a detailed explanation of all the benefits in this discount medical program. The guide includes Terms and Conditions of Your Membership. An excerpt from such Terms and Conditions relative to cancellation is as follows:

A Participant may cancel his or her membership by giving NBAA written notice at any time. If the cancellation of the membership is within 30 days after the effective date of joining the plan, the Participant shall receive a reimbursement of all periodic charges upon return of the discount card to NBAA. Cancellation thereafter will be effective the day notice is received or the end of the period for which dues have been paid, whichever occurs first. Prorated refunds of monthly dues and refund of periods prior to notice will not be made. If NBAA cancels the membership for any reason other than nonpayment of fees by the Participant, NBAA shall make a pro rata reimbursement of all periodic charges to the Participant. New family members may be added by giving NBAA written notice at any time. The effective date of such addition(s) shall be on the 1st day of the subsequent month after receipt of notice by NBAA.

By signing this application for membership, I fully understand that the discount medical benefits are not insurance. I also understand that my membership benefits are not a replacement for health insurance nor are they intended as a substitute for health insurance.