

NATIONAL BENEFIT ADVISORY ASSOCIATION

(A Discount Medical Plan Organization)

FLORIDA DISCOUNT MEDICAL PLAN APPLICATION FOR MEMBERSHIP

PLEASE PRINT

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

Billing Address: _____ City: _____

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

Membership Plan

Discount Medical Plan

DUES: \$ 29.95

TOTAL AMOUNT DUE: \$ 29.95

Payment Modes (Check One):

- | | |
|---|--|
| <input type="radio"/> Monthly Electronic Debit | <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) |
| <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 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)** **Credit Card**

Financial Institution: _____ Card Type: MC VISA AMEX DISCOVER

City: _____ State: FL _____ Cardholder Name: _____

ABA/Routing Number: _____ Account Number: _____

Account Number: _____ Expiration Date: _____

Authorized Signature: _____ Date: _____

Requested Membership Effective Date: _____

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

(See Other Side)

Terms and Conditions of Your Membership (MEMBER AGREEMENT)

THIS IS NOT INSURANCE and does not guarantee payment. This Agreement is between you ("MEMBER") and National Benefit Advisory Association ("NBAA"), and sets out the terms and conditions of the NBAA program which is administered by NBAA. This agreement shall be effective on the date of acceptance of the Member's application for membership in the NBAA program and payment of the membership dues. This membership will be renewed for additional periods, subject to any cancellation of this membership as described below, provided that the required dues for the additional periods are paid to NBAA on or before the date that they are due.

A Member may cancel his or her membership by giving NBAA written notice at any time. If the cancellation of the membership in the discount medical plan organization is within the first 30 days after the effective date of membership in the plan, the Member 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 Member, NBAA shall make a pro rata reimbursement of all periodic charges to the Member. 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.

The NBAA program is not insurance. Rather, it is a discount medical plan whereby the sponsors of the program have negotiated to obtain discounts from the providers of the services and goods. No portion of any provider's fee or cost will be reimbursed or otherwise paid by NBAA. Member is solely responsible for payment of all provider fees and costs. NBAA's discounts cannot be utilized in conjunction with any other discount program.

It is the responsibility of the Member to call the provider network for a list of participating providers in the area, or to verify that a provider is a current participant in the program. Member will always be responsible for payment for the services provided as well as related expenses. The actual services offered by NBAA may vary from state to state, and the list of NBAA's providers is subject to change at any time without further notice to Member. NBAA or its agents have inquired of participating providers to ensure appropriate credentials to provide the requisite services and goods, but may not have performed any additional inquiries as a result of the responses received, and assume no obligation to do so. NBAA does not guarantee or warrant the quality or services or goods delivered by the respective providers to the members.

The actual savings you derive will vary, depending upon your location and the specific service or product purchased. Savings will be derived from a discount from the provider's published fees, as the same may change from time to time. All fees listed or quoted by NBAA are based upon information which providers believe to be accurate. 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. The Terms and Conditions of Your Membership and all of the information contained in the Member's Guide, including the cover, welcome letter (with complaint procedure), disclosure, Member Information, all services, Membership I.D. Cards and the Discount Medical Plan Application for Membership constitute the entire agreement between Member and NBAA, THERE ARE NO WARRANTIES, EXPRESS OR IMPLIED, OTHER THAN EXPRESSLY STATED HEREIN. This agreement may only be amended by NBAA in writing. This agreement shall be governed by the laws of the state of Florida. Any dispute arising from or relating to the agreement may be resolved by voluntary binding arbitration conducted in accordance with the rules of the American Arbitration Association. These provisions shall survive termination of membership in the NBAA program.

Complaint Resolution Procedure: To file a complaint, please put your complaint in writing and either mail your complaint to NBAA, P. O. Box 100877, Fort Worth, Texas 76185-0877, or e-mail your complaint to customerservice@nbaabenefits.com. NBAA shall acknowledge a complaint in writing within 5 business days and investigate a complaint and provide the complainant with the results of its investigation not later than the 30th calendar day after the date NBAA receives the complaint. As part of the complaint resolution procedure, NBAA shall record and track by date all complaints received; investigate all such complaints against NBAA and take all necessary steps to resolve any and all complaints; provide a refund of membership fees as appropriate; and document how it handled each such complaint and how each complaint was resolved. NBAA shall ensure that any and all complaints concerning NBAA's program received by its marketers are handled consistent with this complaint resolution procedure.

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 and does not guarantee or warrant the quality or accessibility of services or goods delivered by the respective providers to the members.

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