| Representative Information | |
|---|---|
| Name: | ___ |
| Agent #: | ___ |

**Association Registration Form**

| Security Information | |
|---|---|
| Verification #: | ___ |
| Confirmation #: | ___ |

## PRIMARY INFORMATION

Last Name: ___ First Name: ___ MI: ___

Street Address: ___

City: ___ State: ___ Zip: ___

Primary Phone #: ___ Mobile Phone #: ___

DOB: ___ Age: ___ ☐ Male ☐ Female Full-time Employed? ☐Yes ☐No

## SPOUSE INFORMATION

Last Name: ___ First Name: ___ MI: ___

DOB: ___ Age: ___ ☐ Male ☐ Female Full-time Employed? ☐Yes ☐No

## DEPENDENT INFORMATION

**Dependent #2** Last Name: ___ First Name: ___ MI: ___
DOB: ___ Age: ___ ☐ Male ☐ Female **Full-time Student *(ages 19-26)* ?** ☐Yes ☐No

**Dependent #3** Last Name: ___ First Name: ___ MI: ___
DOB: ___ Age: ___ ☐ Male ☐ Female **Full-time Student *(ages 19-26)* ?** ☐Yes ☐No

**Dependent #4** Last Name: ___ First Name: ___ MI: ___
DOB: ___ Age: ___ ☐ Male ☐ Female **Full-time Student *(ages 19-26)* ?** ☐Yes ☐No

## BENEFICIARY INFORMATION

**Primary:** Full Name: ___ Relationship to Primary: ___

**Contingent:** Full Name: ___ Relationship to Primary: ___

## MONTHLY MEMBERSHIP DUES

| Foundation Membership | | Limited Membership Options | | Value Memberships | |
|---|---|---|---|---|---|
| **Accident Benefit Levels** | **Prices** | **Programs** | **Prices** | **Packages** | **Prices** |
| ☐ $2K Medical / $10K AD&D | $49.95 | ☐ Physician Networks | $29.95 | ☐ $2K Level Foundation + Physician Networks | $69.95 |
| ☐ $5K Medical / $25K AD&D | $59.95 | ☐ Ancillary Networks | $29.95 | ☐ $5K Level Foundation + Ancillary Networks | $69.95 |
| ☐$10K Medical / $50K AD&D | $69.95 | | | ☐ $5K Level Foundation + Physician + Ancillary + Disability | $99.95 |
| Upgrades: ☐ Disability Income | $10.00 | ☑ Prescription Drugs | Free | ☐ $10K Level Foundation + Physician + Ancillary + Disability | $109.95 |

Enrollment Fees: Individuals = $100 Groups 2 - 25 = $50 Groups 25+ = $10

**Group Accident Insurance Underwritten by Guarantee Trust Life Insurance Company.**

## BILLING INFORMATION

☐Savings ☐Checking **Amt Each Billing Cycle** $ ___

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annually** **Total Initial Charge** $ ___

☐ **ACH/Bank Draft** The Association must be contacted at least 7 business days prior to changing billing mode

Account Holder Name (*as it appears on bank statement* ) ___

Bank Name ___ Requested Billing Date: ☐1st or ☐15th

Bank Transit # ___ Account # ___

☐ **List Billing/Invoice** In order for us to set an account up for paper invoicing we must first receive a quarterly payment. There is a $25 fee associated with each quarterly list bill. Upon receiving your first quarterly payment our Third Party Administrator will begin mailing your quarterly invoices to you each quarte

## AUTHORIZATIONS & DISCLOSURES

AUTOMATIC PAYMENT PLAN AUTHORIZATION: I authorize you to pay and charge to my account by and payable to the order of the authorized TPA for NANP. This authorization is to remain in effect until NANP has received written notification from me of its termination in such time and such manner as to afford NANP a reasonable opportunity to act on it. All monthly dues or fees may be withdrawn from my account on a monthly mode, unless a different mode has been selected on this form.

DISCLOSURES: I understand that this is not an application for insurance, but an information gathering aid that will assist in the enrollment process. The NANP functions independently of any other program as a membership and, other than the group accident, is not insurance. I understand that if I wish to make any changes to the status or terminate my NANP membership, I must contact NANP directly at 1-866-597-NANP. I hereby wish to be enrolled in the NANP. I understand that dues are required to be paid in order to maintain my membership. I hereby designate and appoint the Secretary of NANP 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, to attend and vote on my behalf at any and all meetings of the members, 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 NANP. 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 NANP of my desires in this respect

___
**Account Holder's Signature (as it appears on financial institute records)** ___ **Date**