



# Membership Application

FOR COMPANY USE ONLY:  
 Date Received: \_\_\_/\_\_\_/\_\_\_  
 Effective Date: \_\_\_/\_\_\_/\_\_\_

## PERSONAL INFO

Rep Name: \_\_\_\_\_ Rep Phone: \_\_\_\_\_

First Name	Last Name	Social Security Number	Date of Birth
Address (Billing Address if paying by credit card)		Daytime Phone Number	Age
City	State	Zip Code	Sex
Email Address			

## FAMILY MEMBERS

FAMILY MEMBER NAME	Date of Birth	Age	Sex	Soc. Sec. #
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				

## PLAN CHOICES

*Plan*
No Setup fee
Monthly Dues: Family \$ 75.00

## PAYMENT METHOD

I hereby authorize United Business Association to bill monthly dues to my credit / debit card or bank account, as designated below.

Credit Card
 Credit Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 MasterCard  Visa

Monthly Bank Draft
 Authorized Signature Required Here \_\_\_\_\_ Date \_\_\_\_\_

### AUTOMATIC PAYMENT AUTHORIZATION FORM

To honor checks or electronic funds transfer (ACH) drawn by United Business Association

Account Holder Name \_\_\_\_\_

Bank Name \_\_\_\_\_

Routing / Transit Number \_\_\_\_\_

Account Number \_\_\_\_\_

I authorize United Business Association to draw monthly membership dues from the account above until this authorization is revoked by me.

Date: \_\_\_\_\_ X \_\_\_\_\_ \$ \_\_\_\_\_  
 (SIGNATURE OF BANK DEPOSITOR)- AS SHOWN ON RECORDS FOR THE ACCOUNT TO WHICH THIS AUTHORIZATION APPLIES (AMOUNT)

Notice: This is NOT an individual major medical health insurance plan. The membership benefits included with this plan are intended to supplement and coordinate with a high deductible major medical health insurance plan. Draft for monthly dues will show HA Partners, Inc. on your billing statements.