



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

basic No Setup fee Monthly Dues: Family \$ 10.00

PAYMENT METHOD

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

Credit Card
 MasterCard Visa

Credit Card Number _____ Exp. Date _____

Authorized Signature Required Here _____ Date _____

Monthly Bank Draft

AUTOMATIC PAYMENT AUTHORIZATION FORM

To honor checks or electronic funds transfer (ACH) drawn by Healthy America Association

Account Holder Name _____

Bank Name _____

Routing / Transit Number _____

Account Number _____

I authorize Healthy America 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.