NACD
National Association of Consumers Direct
1819 Clarkson Road, Suite 301
Chesterfield, MO 63017

MEMBERSHIP APPLICATION

APPLE a DAY WELLNESS
be well, stay well
NON-INSURED HEALTH AND WELLNESS PROGRAMS

Name _____

SS# _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Date of Birth _____ **Phone #** _____ **E-Mail** _____

Other Persons in Household

First Name	M.I	Last Name	Date of Birth	Relationship

Dues are $28.00 per Member per month. (Member's Family included)

As a member of the National Association of Consumers Direct, I understand that I am eligible to enroll in the optional limited medical benefits-plans offered. I understand there may be limitations, exclusions, or waiting periods.

To insure uninterrupted benefits, I authorize the automatic renewal of my membership upon expiration.

SIGNATURE _____ DATE _____

Allow 2 to 3 weeks for receipt of your Membership Kit and I.D. card.

Applicant's Signature as Named Above _____ Date _____

Representative _____ Date _____

Payment Authorization

****In order to process your application for the NACD/American Medical Access Plan, you must select one of the following payment options****

☐ DIRECT DEBIT AUTHORIZATION

****You must complete the information below to activate the direct debit payment feature. Remember that a monthly $2 direct debit fee will be added to your total premium. This form must accompany the application.****

I hereby authorize American Benefit Administrative Services, Inc., hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary credit entries and adjustments to my (our) account indicated below and the financial institution named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such amount. This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

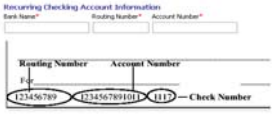
BANK NAME: _____

BANK ADDRESS: _____

_____

ROUTING NUMBER: _____

ACCOUNT NUMBER: _____



Important! Check type of account:
( )Checking ( )Savings

Due to the time required for Company and bank processing, allow 1-2 weeks for processing

_____ _____
CUSTOMER Signature **DATE**

☐ CREDIT CARD AUTHORIZATION

****You must complete the information below to activate the credit card payment feature. Remember that a monthly 2.5% credit card processing fee will be added to your total premium. This form must accompany the application.****

I hereby authorize American Benefit Administrative Services, Inc., hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary credit entries and adjustments to my (our) credit card account indicated below. This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY a reasonable opportunity to act on it.

CREDIT CARD TYPE: ☐ Visa ☐ MasterCard

EXPIRATION DATE: _____ / _____ / _____

CREDIT CARD #:

_____ _____
CUSTOMER Signature **DATE**