AAACare
America's Association for Alternative Care

Enrollment Form

for

America's Association for Alternative Care

All memberships have a $15.00 Activation Fee and a $10.00 Application Fee. These Packages are not available to residents of ME, NY or OR.

Step 1 - Choose Your Membership Package - (check one)

Individual		Family	
Star 1	**Star 2**	**Star 1**	**Star 2**
❑ **$26.50**	❑ **$32.50**	❑ **$31.50**	❑ **$37.50**

Draft Dates: Please check one: ❑1st ❑15th

❑ For optional Total Disability Weekly Income benefit, add $25.00

Step 2 - Tell Us About Yourself

Member Information

Member Name | Gender | Date of Birth

Address | City | State | Zip

Social Security Number | Phone | Email

Dependent Information (if you elected Family Coverage above)

Dependent 1 Name | Relationship | Date of Birth

Dependent 2 Name | Relationship | Date of Birth

Dependent 3 Name | Relationship | Date of Birth

Dependent 4 Name | Relationship | Date of Birth

Step 3 - How Would You Like to Pay?

❑ Bank Account Information

Name of Depositor as it appears on Banking Institution Records

Account Number | Routing/Transit Number | Name of Banking Institution | Branch

❑ Credit Card Information (add one-time $3.00 fee)

❑ Master Card
❑ Visa

Expiration: _____

CCV #: _____

Card Number: | | | | | | | | | | | | | | | |

Authorization to honor checks, share drafts, or account debits

As a convenience to me, I (member) authorize you to pay and charge to my account checks, share drafts, electronic funds transfer debits, credit cards or other account debits made upon my account on the 1st or 15th day of each month prior to the month of coverage by and payable to the order of the entity designated above or its legal representatives for membership, benefits, and/or premium.I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason, you will not be under liability even though dishonor results in the forfeiture of benefits or membership. I further agree that this authorization is to remain in effect until you received written notice of its revocation unless you end it earlier.

X

Member Signature | Date

Step 4 - Read and Sign

I understand that by signing below, I am enrolling in a membership in America's Association for Alternative Care (AAAC) through NIA. I further understand that my membership in AAAC, and access to the AAAC membership benefits, will begin on the first day of the first month immediately following the date my application is received by AAAC. I further understand that member dues, fees, and services are subject to change without notice and that all applications are subject to approval and acceptance by AAAC. I further agree to the Terms and Conditions provided in the National Benefit Plan Brochure. I appoint the Secretary of the Association in office at any particular time as my proxy to receive notice of and attend all meetings of the members and vote on my behalf and to otherwise act for me in the same manner and with the same effect as if I were personally present. This proxy shall be valid until revoked at any time prior to voting at any meeting by executing and delivering a written notice of revocation to the Secretary of the Association, by executing and delivering a subsequently dated proxy to the Secretary of the Association or by voting in person.

X

Member Signature | Date

Step 5 - Congratulations! You Have Completed the Process

NIA

Send completed enrollment form and check payable to AAAC or credit card information to:
AAAC
14800 Quorum Drive, Suite 500
Dallas, Texas 75254

(888) 243-5026 telephone
(214) 342-8699 facsimile
www.aaacbenefits.com

*Representative: (print name)*_____

*Representative Number:*_____