Membership Enrollment

Representative Name: Robert L. Theall
Representative #: A267553
Date: ____________

Name ____________ Male ☐ Female ☐ Date of birth ___/___/___ (mo. day year)
Mailing Address ____________ City ____________
State ____ Zip ______ Phone (____) ____________ SS# ____________
Email address ____________

I am applying for membership in America's Health Care Consumer Association and AmeriValuePlan purchase.

Signature ____________ Date ____________

For Family* Membership: **(attach separate sheet for additional dependents)**

Spouse name ____________ Male ☐ Female ☐ Date of birth ___/___/___ (mo. day year)
Dependent name ____________ Male ☐ Female ☐ Date of birth ___/___/___ (mo. day year)
Dependent name ____________ Male ☐ Female ☐ Date of birth ___/___/___ (mo. day year)
Dependent name ____________ Male ☐ Female ☐ Date of birth ___/___/___ (mo. day year)
Dependent name ____________ Male ☐ Female ☐ Date of birth ___/___/___ (mo. day year)

I hereby designate and appoint the Secretary of America's Health Care Consumer Association (AHCCA) in office at any particular time from this point forward 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 AHCCA. 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 AHCCA of my desires in this respect.

MONTHLY PAYMENT—credit card or bank draft (electronic funds transfer):

☐ **INDIVIDUAL PLAN ....$ 59.00**
(regular monthly payment amount)
+ $ 25.00
(one-time enrollment fee)

☐ **FAMILY PLAN ....$ 69.00**
(regular monthly payment amount)
+ $ 25.00
(one-time enrollment fee)

PAYMENT AUTHORIZATION. SELECT ONE:

☐ **CREDIT CARD:** [ ] VISA [ ] MasterCard Expiration Date ____________
Acct # ____________
Account Holder Name ____________
Credit Card billing address, if different from above ____________
Signature ____________

☐ **BANK DRAFT:** Bank Name ____________
Routing number ____________ Account Number ____________
Account Holder Name ____________ ☐ Checking Account ☐ Savings Account

AUTHORIZATION TO CREDIT CARD COMPANY OR BANK NAMED ABOVE: I hereby authorize America's Health Care Consumer Association (AHCCA) or its plan administrator to charge my credit card account or debit my checking or savings account, as indicated above, for the dues/fees noted above until this authorization is terminated. I further authorize the credit card company or bank named above to pay the charge to my account those payments that are drawn on my account by AHCCA or its plan administrator, and I agree that the credit card company or bank will be fully protected in honoring any such payments and should treat each payment the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the credit card company or bank shall not be liable whatsoever. This authorization remains in effect until terminated by me in writing.

SIGNATURE ____________ DATE ____________

*Family membership in AmeriValuePlan/USA is for individual, spouse and all dependents 21 years of age and under that are residing at the same address.

INSTRUCTIONS

1. Make sure ALL information is accurate.
2. Make sure your email address is accurate so you can receive confirmation.
3. Make sure your date and sign.
4. Fax to 623-691-8107

Office 623-505-6311 • Fax 623-691-8107
rltheall@worldsbest-insurance.com