United Service Association For Health Care
2221 East Lamar Blvd., Suite 900 Arlington, TX 76006 800.872.1187 Fax 855.721.5095

Membership Application

Name (Last, First, MI)_____Social Security #_____

Age____DOB_____Male_____Female_____Residence Address_____

City_____County_____ST_____Zip_____Home Phone(___)_____

Business Phone (___)_____ Cell Phone (____)_____Email Address_____

ELIGIBLE FAMILY MEMBERS I WANT TO ENROLL (LAST NAME, FIRST NAME, MIDDLE INITIAL)

Spouse_____ Relationship_____ Age_____ Date Of Birth_____

Child (under age 26):_____Relationship_____Age_____ Date Of Birth_____

Child (under age 26):_____Relationship_____Age_____ Date Of Birth_____

Child (under age 26):_____Relationship_____Age_____ Date Of Birth_____

Child (under age 26):_____Relationship_____Age_____ Date Of Birth_____

NEW MEMBERSHIP PURCHASE

Dental Care	Initial Amount
☐ Individual ……	$_____
☐ Member+1 ……..	$_____
☐ Family……	$_____

I understand and agree that membership is subject to the terms and conditions of the Membership Agreement. We reserve the right to accept or decline any membership application in accordance with the by-laws that govern our association. In order to ensure that I am able to utilize the benefits, it may be necessary for USA+ to send and/or receive personal information about me to the companies that provide products and services to me. I have 30 days to evaluate the membership and request a full refund.

Applicant's Signature_____ Date _____

Agent's Signature_____ Agent ID#_____ Date_____

INITIAL PAYMENT METHOD

Payment Information if by Credit Card

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ American Express □ Discover

Name on Card:_____ Expiration Date:_____

Account Number:_____ Security Code:_____

(Security Code is required for all credit card orders)

Payment Information if by Check ("EFT")

Name on Account:_____

Account Number:_____

Bank Name:_____

Bank Routing Number:_____

Future Dues to be paid by:

☐ Monthly Bank Draft (EFT) ☐ Monthly Direct Billing ☐ Semi-Annual Direct Billing

☐ Credit Card (CRC) ☐ Quarterly Direct Billing ☐ Annual Direct Billing

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United Service Association For Health Care, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or debit. I further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of membership benefits.

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Authorization of Above charges:

Cardholder / Account Signature_____ Date:_____