



**A-Plus Health Benefits**  
**Guaranteed Acceptance**  
 Supplemental Health Plans

Marketed by  
**NATIONAL INSURANCE**  
**ADVISORS**

**Association and Health Plans Enrollment Application**

Last Name		First Name	
Address		Beneficiary	
City	State	Zip	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth	SSN
Home Phone		Email Address	

**Dependent Information** (Attach additional dependents on a separate sheet)

Name	Soc. Sec. #	Gender	DOB	Relationship

**Health Plan Monthly Premiums**

Please Circle Desired Coverage	Individual	Couple or Member + 1Child	Member & Children	Family Plan
\$2,500 Accident Plan with \$50 Deductible	\$19.95	\$24.95	\$29.95	
\$5,000 Accident Plan with \$50 Deductible	\$29.95	\$34.95	\$39.95	
\$7,500 Accident Plan with \$50 Deductible	\$34.95	\$39.95	\$44.95	
GoldRx \$10/\$20/\$40 Drug Plan	\$19.95	\$24.95		\$29.95
SMART Lab	\$14.95	\$19.95		
Accidental Disability Income Insurance	\$39.95	\$49.95		\$54.95
Critical Illness \$5,000 Benefit	\$24.95	\$44.95		
Term Life Insurance \$15,000 Benefit	\$24.95			
Legal Plan	\$9.95			
Diamond Health Plan	\$59.95	\$64.95		\$69.95
Platinum Health Plan	\$129.95	\$169.95		\$189.95

Total Monthly Premium of All Plans Selected \_\_\_\_\_

Enrollment Fee (\$50)                \$50.00          

Monthly Association Fee (\$2 x number of months)      \_\_\_\_\_

**Total Amount Due With Application**      \_\_\_\_\_

**Total Recurring  
 Monthly Payment**      \_\_\_\_\_

*Applications and Fees received on or before the 15<sup>th</sup> of the month will be effective the 1<sup>st</sup> of the following month.  
 Applications and Fees received after the 15<sup>th</sup> will be effective the 15<sup>th</sup> of the following month.*

Agent Name: _____	Agent Number: _____
Agent Signature: _____	Requested Effective Date (1 <sup>st</sup> or 15 <sup>th</sup> ):      /      /20

**Application Conditions and Agreement**

*IMPORTANT: It is important that you carefully read and fully understand the following: All Applicants age 18 and over must personally read, agree to and sign the application.*

**Agreement (all applicants)**

By applying for Association Membership I, the undersigned, agree to the following:

1. Any of my lawful dependents are listed on this application and those over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything to assure that all the information provided on this application is true and accurate to the best of my knowledge as of the date signed. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for benefits if any information is false or incomplete and that the SMART Healthcare Association may revoke my membership and benefits if it discovers that any information on this application is incomplete or false.
2. If the applicant is a minor, I accept full legal and financial responsibility for the benefits and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

**I have personally read and completed this application.** This application will become part of the contract between the Association and I. I and any enrolled family members agree to abide by the members' terms and conditions of that contract.

**Arbitration:** I agree that any dispute between me or any enrolled family member, and the SMART Healthcare Association of America must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limits of the Small Claims Court. Any such dispute will be resolved not by lawsuit or resort to court process, except as the law provides for judicial review or arbitration proceedings. Under these conditions, both I and my enrolled family, and the SMART Healthcare Association of America are giving up the right to have any dispute in a court of law before a jury. The SMART Healthcare Association of America and the Member also agree to give up any right to pursue on a class basis any claim or controversy against the other.

**The SMART Healthcare Association of America - Privacy Practices Notice**

**The Association appreciates the trust you place in us. You trust us with your private personal information and we recognize our obligation to keep information about you secure and confidential. To provide you with the highest quality products and services, we must collect a certain amount of personal information about you. It is important for you to know that we do not sell or share customer information with outside marketers. Our information sharing practices are designed to protect the confidentiality of your information.**

**We collect personal information about you from the information you provide on applications or other forms, such as your name, address, and social security number.**

**We treat your information with respect and concern for your privacy. We do not disclose any non-public personal or financial information about our customers or former customers to anyone, except as required or permitted by law. In addition to reasonable electronic security measures, our security practices include limiting access to those employees, independent representatives, and business associates with appropriate authority and for intended business purposes only.**

**If we allow limited access or any type of disclosure to permitted persons it is done to service your health plan, claims, or to inform you about other products and services we offer. Before disclosing your information, we require these companies or individuals to promise to follow our privacy and use it only for the transaction we request.**

**Signatures (Required) – IMPORTANT: All applicants over age 18 must sign and date the application**

Applicant/Parent or Legal Guardian <b>X</b>	Today's Date	Applicant's Spouse <b>X</b>	Today's Date
Applicant age 18 or over <b>X</b>	Today's Date	Applicant age 18 or over <b>X</b>	Today's Date

**PREFERRED PAYMENT METHOD (Select Only One)**

**Monthly Checking Account Automatic Deduction For:**

- Monthly premium payments and monthly Association dues (\$2.00)
- For the negotiated (discounted) fees for medical services and treatment

**Name of Bank or Financial Institution:** \_\_\_\_\_

**Account No:** \_\_\_\_\_ **Bank Routing No:** \_\_\_\_\_

Submit one (1)-month's premium, the initial processing fee (\$50.00) and the first month's Association membership dues (\$2.00) and a blank check marked "Void". The subsequent premiums for all products selected and/or the Association dues will be deducted from your checking account. If the account listed above is a joint account, both account holders' signatures are required.

**Monthly Checking Account Deduction Authorization** - As a convenience to me, I request and authorize you to pay and charge to my checking account amounts drawn on that account by and payable to the order of The SMART Healthcare Association of America, or National Marketing Group Inc., 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 debit shall be the same as if it were a check personally written to you and signed personally by me. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit 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 forfeiture of benefits. **For Diamond, or Platinum Plan participants** - If I have not paid for medical services within 30-days, I authorize the TPA of the SMART Healthcare Association of America or National Marketing Group Inc., to debit my checking account for the discounted amount of the medical treatment I receive.

*NOTE: Should your withdrawal not be honored by your bank, you will automatically be suspended from receiving any benefits of the Association and you may incur a \$25 service charge for any withdrawal not honored.*

<b>Authorized Signature</b> <i>(As it appears in the financial institution's records)</i>	<b>Authorized Signature</b> <i>(As it appears in the financial institution's records)</i>
<b>X</b> _____ <b>DATE</b>	<b>X</b> _____ <b>DATE</b>

**Periodic Direct Billing**

**OPTIONAL Payment Method: I request the direct billing below option so that I can write a check for my payments. Direct billing has a \$5.00 service charge per billing cycle. (Note: Direct Billing is not available for monthly billing)**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Spouse** \_\_\_\_\_ **Date** \_\_\_\_\_

- rQuarterly billing initially requires 3-month's premium\*, thereafter a 3-month billing cycle.**
- rSemi-annual billing initially requires 6-month's premium\*, thereafter a 6-month billing cycle.**
- rAnnual billing initially requires 12-month's premium\*, thereafter a 12-month billing cycle.**

\*Plus the one-time Enrollment fee (\$50.00) and \$6 for quarterly, \$12 for semi-annual or \$24 for annual Association Dues.

*I understand that enrollment into the SMART Healthcare Association of America entitles me to enroll myself and all eligible dependents into the A Plus Health Plans and the Association's Group Blanket Guaranteed Issue insurance products. I acknowledge that the A Plus Health Plan is not an insurance policy. The member understands that A Plus Health Plan is a professional Health Care Savings Plan, and not an insurance plan. By presenting your SMART Care membership card to the provider, you will receive a substantial savings off of the provider's regular fee. Actual savings vary depending on the nature of the service rendered. The A Plus Health Plan will make no payments to medical providers. I understand that in order to receive the plan savings, I must use participating providers and pay the providers promptly for all services received. I agree to review the Members Terms and Conditions on page 4 of this application and a copy will be in my Guide to Member benefits. I also understand that neither the Agent/Representative, the Association, A Plus Health Plans, nor the PPO networks accessed are responsible for the outcome of the medical care needed or the cost of that care.*

### **Association Member Terms and Conditions**

1. The member understands that A Plus Health Plans is a professional Health Care Savings Plan, and not an insurance plan. By presenting your A Plus Health Plans membership card to the provider, you will receive a substantial savings off of the provider's regular fee. Actual savings vary depending on the nature of the service rendered. A Plus Health Plans will make no payments to medical providers.
2. The member understands that the A Plus Health Plans \$50.00 Doctor office visit reimbursement benefit is limited to a maximum number of office visits per year. See pages 5-6 for complete benefit description and annual limitations. There is a 30-day waiting period from the plan effective date for the \$10 office visit benefit to become effective.
3. The A Plus Health Plans provides medical savings to its members through a number of medical networks by negotiating discounts the costs for treatment and services. In order to access these networks and the related discounts, the member or the member's dependents must pay the medical providers by authorizing the checking account listed on the front of this application or by providing a credit card for prompt payment. The negotiated (discounted) charges on all medical bills are due and payable at the time of service, but by agreeing to pay by checking account debit or credit card, you will be notified of the amount of the costs prior to the actual debit. The member has no out-of-network benefits, must use a contracted provider in order to receive benefits, and agree to payment for treatment and services as stated above.
4. The member understands that the use of the program for hospitalization or surgery can only be utilized when members contact the Hospital advocacy department PRIOR to scheduling the event.
5. Neither A Plus Health Plans nor any of its affiliates shall be liable for any payment to a provider accessed under the A Plus Health Plans, or any refusal of participating providers to accept the negotiated rates offered to the provider. The A Plus Health Plans its affiliates or any network accessed is not an insurer, guarantor or underwriter for the responsibility or liability for the member's or the Member's dependent's medical care or any other goods or services provided to the member or the member's dependents.
6. The providers listed in the PPO networks are subject to change without notice. Member must call the patient advocacy department referral line at (888) 350-1500 for current provider status. See pages 4 to 9 for more information on locating a doctor, member advocacy, and the \$50 Doctor office visit reimbursement benefit. Participating Medical Providers are independent contractors. The A Plus Health Plans and its affiliates are not responsible for health care provided or the omission of any health care by any provider. The SMART Healthcare Plan does not practice medicine or in any manner interfere with or participate in the provider-patient relationship. All health care decisions are between the patient and the provider. The selection of a provider from our participating providers is the obligation and decision of the patient and is not based upon the credentialing or any recommendation by The A Plus Health Plans, its affiliates, or its contracted networks.
7. A Plus Health Plans reserves the right to terminate any member or deny eligibility in the program for lack of payment to a provider, failure to pay the monthly premium, or failure to pay the annual Association dues. Returned checks or insufficient funds notice on a returned bank draft, is evidence of non-payment by the member. A Plus Health Plans reserves the right to terminate membership or deny eligibility in the program for failure to pay a medical provider accessed under the A Plus Health Plans Plan under the terms stated herein. The member is responsible for the full amount of any health care services received after the date of termination.
8. All health plan enrollment is on a month-to-month basis. Members may cancel their health plan at any time upon providing written notice 10-days prior to their next billing due date. Association dues are paid annually and there is no pro-rated refund due the member if the member terminates enrollment into the Association. Termination from the Association will be effective on the next annual renewal date.
9. The A Plus Health Plans reserves the right to access a late charge of \$15.00 if the monthly or quarterly premiums are not received within 10 days prior to the next due date. Furthermore, The A Plus Health Plans reserves the right to access a \$25.00 charge for returned checks or from insufficient funds on automatic bank drafts.
10. The administrator for Group Blanket Accident Insurance providing coverage to all A Plus Health Plans members is responsible for all accident injury determination and payment of benefits. Eligibility for Emergency Medical Air Services and Emergency Travel Assistance, provided by Travel Assist, is effective after 30-days enrollment into the SMART Health Care Plan. (NOTE: Emergency Medical Air Service is limited by law to \$2,500 in Hawaii and Alaska.)
11. The Healthcare Plan monthly premiums are guaranteed for 6-months. Premium increases may be changed for all enrolled members, (but not individually), upon 30-days notice. The Group Blanket Accident, Disability, Term Life, Critical Illness, and RX Plans are subject to annual rate increases on the policy renewal date.
12. The administrator of the Disability Insurance is responsible for determination of all partial and total disability, Accidental Death & Dismemberment, and payment of benefits. See your member's "Guidebook to Member Benefits" for specific claims filing information. In all cases, payment of benefits is determined by the definitions and policy procedure.
13. The member acknowledges the GoldRx Plan is not an insurance policy. It is a four-tier negotiated fee formulary drug plan and participating pharmacies must be used to receive the benefit; viz, the payment of the negotiated fee or the negotiated discount for the prescription filled.

Applicant Initials: \_\_\_\_\_ Spouse Initials: \_\_\_\_\_ Date: \_\_\_\_\_