Membership Application

Representative Name: _____
Representative #: _____
Date: _____

Fax Application To: 469-547-8389

Name _____ Male ❑ Female ❑ Date of birth ___/___/___ (mo. day year)

Mailing Address _____ City _____

State _____ Zip _____ Phone (____) _____

Email address _____

I am applying for membership in My Health Assistant.

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)

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

MY HEALTH ASSISTANT

❑ **Individual.....$ 19.95**
❑ **Family.....$ 19.95**

(regular monthly payment amount)
+ $3.95 one-time application fee

PAYMENT AUTHORIZATION. SELECT ONE:

❑ CREDIT CARD: [ ] VISA [ ] MasterCard [ ] American Express [ ] Discover 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 Access Plans USA or its 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 Access Plans USA 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.

The terms and conditions of membership are set forth in your membership guide. If you cancel your Membership during the first 30 days by notifying us in writing and returning your ID cards, you will receive, within 30 days, a full refund of membership dues excluding the one-time enrollment fee (except where prohibited by state law). My Health Assistant is not affiliated with any state or federal government agencies. Features and providers are subject to change. My Health Assistant and Access Plans USA are not responsible for medical advice given by providers, and services provided by My Health Assistant are not intended to replace care by a personal physician.

SIGNATURE _____ DATE _____

*Family membership in My Health Assistant includes all IRS-qualified dependents.