

Membership Application



Name _____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ SS# _____

Ph. # _____ E-mail _____

Other Persons in Household

First Name	M.I	Last Name	Date of Birth	Relationship

Dues are \$10.00 per Member per month. (Member's Family included)

As a member of the National Association of Consumers Direct, I understand that I am eligible to enroll in the optional limited medical benefits-plans offered. I understand there may be limitations, exclusions, or waiting periods.

To insure uninterrupted benefits, I authorize the automatic renewal of my membership upon expiration.

SIGNATURE _____

DATE _____

Allow 2 to 3 weeks for receipt of your Membership Kit and I.D. card.

Applicant's Signature as Named Above _____

Date _____

Representative _____

Date _____