



MEMBER INFORMATION			
I am applying to the National Better Living Association ("NBLA"), a Georgia nonprofit, nonstock corporation, for membership ("Membership") in the Membership Plan indicated below. I understand that I will not become an NBLA member unless and until NBLA accepts my application. I understand I can cancel my NBLA membership for any reason within 30 days from the date of this application and receive a refund of membership fees. I have read and signed this application and the payment authorization at the bottom of this page.			
Name (First, Middle, Last)			Home Telephone
Street Address		Date of Birth	Work Telephone
City	State	Zip code	Email Address (optional to receive program updates)

MEMBERSHIP CLASS (PLAN) SELECTION							
	NBLA Basic Wellness	NBLA My Wellness Plus	NBLA Basic Gold	NBLA 250	NBLA 300	NBLA 500	NBLA 1000
INDIVIDUAL	<input type="checkbox"/> \$138 (Annual)	<input type="checkbox"/> \$22	<input type="checkbox"/> \$32	<input type="checkbox"/> \$199	<input type="checkbox"/> \$249	<input type="checkbox"/> \$279	<input type="checkbox"/> \$379
INDIVIDUAL +1	N/A	N/A	N/A	<input type="checkbox"/> \$309	<input type="checkbox"/> \$389	<input type="checkbox"/> \$469	<input type="checkbox"/> \$559
FAMILY	<input type="checkbox"/> \$138 (Annual)	<input type="checkbox"/> \$26	<input type="checkbox"/> \$36	<input type="checkbox"/> \$319	<input type="checkbox"/> \$419	<input type="checkbox"/> \$539	<input type="checkbox"/> \$649
ADMIN FEE	\$10	\$10	\$10	N/A	N/A	N/A	N/A
ENROLL/ ACTIVATE FEE	\$110	\$110	\$110	\$110	\$110	\$110	\$110
OPTIONAL INSURANCE BENEFIT - (INSURED DENTAL)							
INDIVIDUAL	N/A	N/A	N/A	<input type="checkbox"/> \$24	<input type="checkbox"/> \$24	<input type="checkbox"/> \$24	<input type="checkbox"/> \$24
FAMILY	N/A	N/A	N/A	<input type="checkbox"/> \$39	<input type="checkbox"/> \$39	<input type="checkbox"/> \$39	<input type="checkbox"/> \$39
TOTAL							

DEPENDENT INFORMATION (if Family Membership Selected)			
Spouse: <input type="checkbox"/> M <input type="checkbox"/> F	Full Name	DOB ____/____/____	Full-Time Employer / Accredited School
			Hrs Worked/Attended
Dependent1: <input type="checkbox"/> M <input type="checkbox"/> F	Full Name	DOB ____/____/____	Full-Time Employer / Accredited School
			Hrs Worked/Attended
Dependent2: <input type="checkbox"/> M <input type="checkbox"/> F	Full Name	DOB ____/____/____	Full-Time Employer / Accredited School
			Hrs Worked/Attended

REFUND POLICY
31Day Free Examination Period. Please examine Your certificate. Within 31 days after delivery, You can return it to the Administrator with Your written request for a refund of all memberships paid. When requested, membership will be null and void from its inception.

PAYMENT OPTIONS (Choose One)			
1. <input type="checkbox"/> Bank Draft	Routing Number (9 digits)	Account number <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
2. <input type="checkbox"/> Debit or Credit Card	Account Number	Expiration Date (mmyy)	CVV code:

AUTHORIZATION	
I hereby request and authorize my Bank to charge my account for drafts or EFT notices drawn by National Better Living Association or its agent, Allied Health Benefits, Inc. (AHB). If paying by credit card, I authorize the National Better Living Association or its agent, AHB to charge my card the amount detailed in this application. This authorization shall remain in effect until revoked in writing and in accordance with the currently published cancellation clause in the NBLA Membership Terms & Conditions, and the bank receives such notice. I agree that NBLA and AHB shall be fully protected in charging such payments to my account. I agree that NBLA's and AHB treatment of and rights in respect to each charge shall be the same as if it were personally signed by me. I further agree that should any such charge be dishonored, whether with or without cause, or intentionally or unintentionally, NBLA and AHB shall have no liability whatsoever if such dishonor results in the forfeiture of any Benefits of Membership or the NBLA Program. I have instructed NBLA and AHB to send this authorization to my Bank or Credit Institution.	
SIGNATURE	DATE
Please complete this form and fax to 800-622-0811 or mail to: The Benefit Solutions Group, 3948 Legacy Drive, Suite 106, Box 379, Plano, TX 75023-8300	
Office Use Only	Agent # 63567
IMR Name: Delyn Reed	