Type in your information below, Print it out, Sign and then Fax to (801) 386-5499

ACCIDENT SHIELD

SUPPLEMENTAL BENEFITS PLAN

MEMBERSHIP APPLICATION

WBA
Wholesale Benefits Association

Last Name | First Name | Initial | Date of Birth

Address | Phone # | E-Mail Address

City | State | Zip Code | Social Security #

Spouse (if included) | Date of Birth

1. Dependent (if included) | Date Of Birth
2. Dependent (if included) | Date Of Birth
3. Dependent (if included) | Date Of Birth
4. Dependent (if included) | Date Of Birth
5. Dependent (if included) | Date Of Birth
6. Dependent (if included) | Date Of Birth
7. Dependent (if included) | Date Of Birth
8. Dependent (if included) | Date Of Birth

Complete ONLY If List Bill or Payroll Deduction Through Employer

N/A — Employer/Company Name

N/A — Employer/Company Phone #

$5000 Accident Shield				
	Monthly/PAC	Quarterly/PAC	Semi-Annual	Annual
Single	$22.00	$66.00	$121.00	$220.00
Family	$35.00	$105.00	$192.00	$350.00
$10,000 Accident Shield				
Single	$34.00	$102.00	$187.00	$340.00
Family	$47.00	$141.00	$258.00	$470.00

Add $10.00 One Time admin fee to initial payment.
Monthly & Qt direct bill add $2.50 per billing period.
Monthly direct bill requires 2 month's premium upon submission.
Group List Bill available. Ask Representative for details.

Type in Chosen Rate Below: New $7,500 option available! $28/mo Single & $41/mo Family

____ Chosen Rate + ____ Direct Bill + 10.00 One Time Fee = ____ Initial Payment

I hereby apply for membership with WBA and I authorize WBA and/or its authorized agent to charge my credit card for all future renewal premiums as they come due, or; I hereby request and authorize you to pay checks drawn on my account by WBA and/or its authorized agent and payable to same provided there are sufficient collected funds in said account to pay the same upon presentation, or; I authorize my employer to deduct from my earnings the required contribution, if applicable. This authorization is to remain in effect until WBA receives written notification from me revoking the authorization. I will notify WBA in writing of my wish to cancel the membership 30 days in advance.

X

Member Signature | Date

Payment Option

☐ Check ☐ Credit Card ☐ Employer Sponsor

Payment Mode

☐ MPAC ☐ QPAC ☐ S/A ☐ ANN
(PAC Attach Void Check)

☐ Direct Mo ☐ Direct QT (Add $2.50 DIRECT)

Make Check Payable to: WBA

Credit Card Information

☐ VISA ☐ MC ☐ DISCOVER ☐ AMEX

Card Number | Expiration (Mo/Yr)

Name on Credit Card

Gregory W. Davies — Producer Name | #50250 — Producer #

Mail Application To: Comprehensive Insurance Agency – 3601 Algonquin Rd. Suite 605 – Rolling Meadows, IL 60008 OR FAX TO: 847-483-9485

Local Agent: Greg Davies (801) 406-9502

Attach Void Check Below

VOID CHECK