United Service Association For Health Care
2221 East Lamar Blvd., Suite 900 Arlington, TX 76006 800.872.1187 Fax 855.721.5095

Membership Application

First Name *MI* *Last Name*

Name _____ Age____DOB_____ ☐Male ☐Female

Residence Address_____

City_____ST_____Zip_____

Home Phone(___)_____ Business Phone (___)_____ Cell Phone (____)_____

Email Address_____

Beneficiary Name_____DOB_____Relationship_____

Contingent Beneficiary Name_____DOB_____Relationship_____

NEW MEMBERSHIP PURCHASE – ValULife

☐ ValULife 10 $42.00 ☐ ValULifeSilver $69.00 ☐ValULife25 $65.00

I understand and agree that membership is subject to the terms and conditions of the Membership Agreement. I agree to the purpose of the association, which includes in part, promoting equitable public health care policy in the United States, increasing the number of medical providers available to provide medical services, providing educational materials and assisting charitable, educational and social welfare organizations in the conduct of similar activities. USA+ reserves the right to accept or decline any membership application in accordance with the by-laws that govern the association. In order to ensure that I am able to utilize the benefits, it may be necessary for USA+ to send and/or receive personal information about me to the companies that provide products and services to me. Personal information includes the following: name, social security number, phone number and date of birth. I have 30 days to evaluate the membership and request a full refund.

Applicant's Signature_____ Date _____

Agent's Signature_____ Agent ID#_____ Date_____

Payment Information if by Credit Card

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card:_____ Expiration Date:_____

Account Number:_____ Security Code:_____

(Security Code is required for all credit card orders)

Payment Information if by Check ("EFT")

Name on Account:_____

Account Number:_____

Bank Name:_____

Bank Routing Number:_____

Billing Address ☐ Same as Mailing

Name (First, MI, Last)_____

Address_____City_____State_____Zip_____

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United Service Association For Health Care, 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 check or electronic debit shall be the same as if it were a check drawn on you and signed by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check or debit. I further agree that if any such checks or electronic debits 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 the forfeiture of membership benefits. I agree not to dispute this recurring billing with my bank or card issuer so long as the transactions correspond to the terms indicated in this authorization form.

Authorization of Above charges:

Cardholder / Account Signature_____ Date:_____

Applicant Signature_____ Date:_____