Effective Date_____

# NATIONAL MEDICAL SERVICES PROFILE & AGREEMENT

**Applicant Name**_____ **Social Security #**_____

**Home Address** _____ **Date Of Birth**_____

_____ **Home Phone**_____

**E-mail**_____ **Work Phone**_____

**Height** _____ **Weight**_____ **Cell Phone**_____

| Family Members On Plan | Soc. Sec. # | Date of Birth | Height | Weight |
|---|---|---|---|---|
| **Spouse** _____ | _____ | _____ | _____ | _____ |
| **Child # 1** _____ | _____ | _____ | _____ | _____ |
| **Child # 2** _____ | _____ | _____ | _____ | _____ |
| **Child # 3** _____ | _____ | _____ | _____ | _____ |

## PRE-AUTHORIZED PAYMENT PLAN

**National Medical Services or its administrators are hereby authorized to initiate debit entries, whether by electronic or paper means, with said debit drawn on my account until this authorization is terminated by written notice to National Medical Services. If any such payment is dishonored whether with or without cause, I understand that the bank and National Medical Services shall not be liable whatsoever even though such dishonor results in forfeiture of the benefits associated with the plan.**

**I understand that this debit may occur up to seven (7) days before the beginning of the month for which the debit is assigned; and if I wish to terminate the plan, I will give instructions to do so in writing at least seven (7) days prior to the start of the month.**

**Account Holder's Name:**_____

**Electronic Signature:**_____ **Date:** _____

**By signing below, I agree that all information provided above is complete, accurate, and truthful. I recognize that because of the high cost of health insurance, National Medical Services has attempted to put together a " Medical Costs Warranty Program" which allows clients to purchase reasonably priced hospitalization insurance from well-known A-rated Insurance companies and combine it with a product that is not insurance to better suit the clients' needs. It has been explained to me and I understand that anything associated with this program and its rebates should in no way be considered to be insurance, but rather an affordable alternative to satisfy the need to reduce medical costs.**

**Electronic Signature:**_____ **Date:**_____

Name:_____

Address:_____ DATE _____

City, State, Zip:_____

PAY
TO THE
ORDER OF National Medical Services $

_____ DOLLARS

Bank Name:_____

_____
Electronic Signature

Routing #:_____ Account#:_____

Submit