



Consumer Driven Benefits Association
 515 New Jersey St. Suite G, Redlands, CA 92373
 Phone: 800-303-8110 Fax: 909-335-8469
 www.cdba.us

Last Name		First Name	
Address		Beneficiary	
City		State	Zip Code
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth :	SSN :
Home Phone		E-mail Address	

Dependent Information (Attach additional dependents on a separate sheet)				
Name	DOB	Gender	Relationship	SS#

APPLICATION FOR MEMBERSHIP IN THE CONSUMER DRIVE BENEFITS ASSOCIATION

	<u>Place an X in the far left column for the desired benefits</u>	Member	Couple	Member & Children	Family
X	Discount Healthcare Benefits Included in all membership levels	FREE	FREE	FREE	FREE
	CONSUMER VALUE LEVEL (High Option)	\$210.00	\$371.00	\$358.00	\$399.00
	CONSUMER VALUE LEVEL (Low Option)	\$164.00	\$305.00	\$307.00	\$316.00
Upgrade Group Membership Level to Include:					
	Indemnity Dental Insurance Plan				
	Short Term Accident Disability Income Insurance				
	Long Term Disability Income Insurance				
	\$10,000 Critical Illness Insurance				
	Total Monthly Fee with and Upgrades to membership	\$	\$	\$	\$
	1-Time Association Enrollment Fee	\$100.00	\$100.00	\$100.00	\$100.00
	Total Amount of Initial Check:	\$	\$	\$	\$

Applicants Signature:	Print Name:
Sales Representative:	Agent Code:
Date:	Marketed By: Medical Benefits Network 1080 Greentree Rd. Pittsburgh, PA 15220 Phone #: 888-831-7886 Fax #: 412-341-8700
This is Not Insurance	

PAYMENT METHOD—Checking Account Automatic Deduction For:

Initial monthly Fee and 1-Time Association processing fee (\$100.00)

Monthly Membership Fee payment

Name of Bank or Financial Institution:

Account Number:

Bank Routing Number:

Submit one (1)-month's fees, the initial processing fee (\$100.00) and a blank check marked "VOID". The monthly fee for your membership will be deducted from your checking account. If the account listed below is a joint account, both account holders' signatures are required.

Monthly Checking Account Deduction Authorization — As a convenience to me, I request and authorize a transfer from my checking or savings account by electronic funds transfer or paper draft an amount payable to the order of Medical Benefits Network to pay the membership dues provided by the association given there are sufficient collected funds in said account to pay upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check personally written to you and signed personally by me. This authority is to remain in effect until revoked by me by providing you with a 30-day written notice of change or cancellation. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit 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 forfeiture of benefits. NOTE: Should your withdrawal not be honored by your bank, you will automatically be suspended from receiving any benefits of the Association including the special discount pricing on your medical treatment and you may incur a \$25 service charge for any withdrawal not honored.

Authorized Signature (As it appears in the financial institution's records)

X

Date:

Authorized Signature (As it appears in the financial institution's records)

X

Date:

I understand that enrollment into the Consumer Driven Benefits Association entitles me to enroll myself and all eligible dependents into the Association and the Association's Group Blanket Guaranteed Issue insurance products. I acknowledge that the Association medical healthcare benefit of access to negotiated fees for lab and diagnostic testing is not an insurance policy and are included in my membership benefits at no additional cost. By presenting my membership ID card to other ancillary healthcare providers, you will receive a substantial savings off of the provider's regular fee by accessing a negotiated fee schedule. Actual savings vary depending on the nature of the service rendered. The Association will make no payments to medical providers. I understand that in order to receive the plan savings, I must use participating providers and pay the providers promptly for all services received. I agree to the Members Terms and Conditions on page 4 of this application and a copy will be in my Guide to Member benefits. I also understand that neither my local Representative, the Association, nor the endorsed healthcare plan are responsible for the outcome of the medical care needed or the cost of that care.

Signatures (Required) — IMPORTANT: All applicants over age 18 must sign and date the application.

Applicant / Parent or Legal Guardian

Today's Date

Applicant's Spouse

Today's Date

X

X

Applicant age 18 or over

Today's Date

Applicant age 18 or over

Today's Date

X

X

Association Member Terms and Conditions

1. The member understands that the medical benefits are provided in my Association membership package at no additional cost. Any savings I receive is through the pre-pay arrangement provided by the Association and is not an insurance plan. My Association Membership provides access to a pre-payment service for laboratory and diagnostic testing. By agreeing to pre-pay for medical tests, I can access the negotiated fee schedule and receive a substantial savings from the testing regular fees. Actual savings vary depending on the nature of the test performed. The Association will make no payments to medical providers.
2. The member understands that the Association \$50.00 Doctor Office visit reimbursement benefit is limited to a maximum number of office visits per year. See pages 3-13, 3-14, or 3-17 for complete benefit description and annual limitations. There is a 30-day waiting period from the plan effective date for the \$50 office visit benefit to become effective.
3. The discounted ancillary healthcare benefits provide savings to its members through a number of healthcare providers by accessing the negotiated fees for treatment and services. In order to access these providers and capitalize on the savings, the member or the member's dependents must pay the providers at the time of service, by authorizing the debiting of the checking account listed on the front of this application, or by providing a credit card for prompt payment. You must use a participating provider in order to receive benefits and agree to payment for treatment and services as stated above.
4. The member understands that the savings for hospitalization or surgery can only be utilized when members follow the access procedures of pre-registration on pages 1-4 to 1-6 of the Guide to Member's Benefits PRIOR to scheduling the event.
5. Neither the Association nor any of its affiliates shall be liable for any payment to a provider accessed under the healthcare benefits, or any refusal of participating providers to accept the negotiated rates offered to the provider. The Association, its affiliates or any participating provider accessed through your Association membership is not an insurer, guarantor or underwriter for the responsibility or liability for the member's or the Member's dependent's medical care or any other goods or services provided to the member or the member's dependents.
6. The Participating Providers are subject to change without notice. The member or dependent must call a participating provider prior to scheduling an appointment and present their membership ID card at the time of treatment. See the Guide to Member's Benefits for current provider status or call 800-350-1500 and follow the prompts. See section 1 of the Guide to Member's benefits for more information on locating a provider. Participating healthcare providers are independent contractors. The Association and its affiliates are not responsible for health care provided or the omission of any health care by any provider. The Association does not practice medicine or in any manner interfere with or participate in the provider-patient relationship. All health care decisions are between the patient and the provider. The selection of a provider from our participating providers is the obligation and decision of the member and is not based upon the credentialing or any recommendation by the Association, its affiliates, or its participating providers.
7. The Association reserves the right to terminate any member or deny eligibility in the program for lack of payment to a provider or failure to pay the monthly Association fee. Returned checks or insufficient funds notice on a returned bank draft, is evidence of non-payment by the member. The Association reserves the right to terminate membership or deny eligibility in the program for failure to promptly pay a healthcare provider. The member is responsible for the full amount of any health care services received after the date of termination.
8. Association membership is on a month-to-month basis. Members may cancel their membership at any time upon providing written notice 10-days prior to their next billing due date. Termination from the Association will be effective on the next renewal date. The Association's 1-time enrollment and processing fee is non-refundable.
9. The Association reserves the right to access a late charge of \$15.00 if the Association Fees are not received within 10 days prior to the next due date. Furthermore, the Association reserves the right to access a \$25.00 charge for returned checks or from insufficient funds on automatic bank drafts.
10. The administrator of the Accident, Disability, Critical Illness, AD&D, Term Life Insurance and all other group insurance policies is responsible for determination of all benefits and payment of benefits. See your member's "Guidebook to Member Benefits" for specific claims filing information. In all cases, payment of benefits is determined by the master group policy definitions, procedures, and amendments in place at the time of claim. Eligibility for Emergency Medical Air Rescue Services and Emergency Travel Assistance, provided by Life Guard, is effective after 30-days enrollment into the Association. (NOTE: Emergency Medical Air Service is limited by law to \$2,500 in Hawaii and Alaska.)

The initial Association membership fee is guaranteed for 6-months. Increases in Association fees may be changed for all members within a membership level and/or group, (but not individually), upon 30-days notice; however, the monthly membership fee is subject to increases on the supplemental insurance plans at the annual policy renewal dates. This could cause the monthly membership fee to be increased within the 6-month guarantee period.

12. The member acknowledges the SMART GoldRX Plan is not an insurance policy. It is a four-tier negotiated fee formulary drug plan and participating pharmacies must be used to receive the benefit; viz, the immediate payment of the negotiated fee or the negotiated discount for the prescription filled.

Applicant Initials:

Date:

Spouse Initials:

Date:

The access to medical laboratory and diagnostic testing is provided at no additional cost to Association members.

Application Conditions and Agreement

IMPORTANT: It is important that you carefully read and fully understand the following: All Applicants age 18 and over must personally read, agree to and sign the application.

Agreement (all applicants)

By applying for Association Membership I, the undersigned, agree to the following:

1. Any of my lawful dependents are listed on this application and those over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything to assure that all the information provided on this application is true and accurate to the best of my knowledge as of the date signed. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for benefits if any information is false or incomplete and that the Consumer Driven Benefits Association may revoke my membership and benefits if it discovers that any information on this application is incomplete or false.
2. If the applicant is a minor, I accept full legal and financial responsibility for the benefits and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

I have personally read and completed this application. This application will become part of the contract between the Association and I. I and any enrolled family members agree to abide by the members' terms and conditions of that contract.

Arbitration: I agree that any dispute between me or any enrolled family member, and the Consumer Driven Benefits Association must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limits of the Small Claims Court. Any such dispute will be resolved not by lawsuit or resort to court process, except as the law provides for judicial review or arbitration proceedings. Under these conditions, both I and my enrolled family, and the Consumer Driven Benefits Association are giving up the right to have any dispute in a court of law before a jury. The Consumer Driven Benefits Association and the Member also agree to give up any right to pursue on a class basis any claim or controversy against the other.

The Consumer Driven Benefits Association - Privacy Practices Notice

The Association appreciates the trust you place in us. You trust us with your private personal information and we recognize our obligation to keep information about you secure and confidential. To provide you with the highest quality products and services, we must collect a certain amount of personal information about you. It is important for you to know that we do not sell or share customer information with outside marketers. Our information sharing practices are designed to protect the confidentiality of your information.

We collect personal information about you from the information you provide on applications or other forms, such as your name, address, and social security number.

We treat your information with respect and concern for your privacy. We do not disclose any non-public personal or financial information about our customers or former customers to anyone, except as required or permitted by law. In addition to reasonable electronic security measures, our security practices include limiting access to those employees, independent representatives, and business associates with appropriate authority and for intended business purposes only.

If we allow limited access or any type of disclosure to permitted persons it is done to service your health plan, claims, or to inform you about other products and services we offer. Before disclosing your information, we require these companies or individuals to promise to follow our privacy and use it only for the transaction we request.

Agent Name:

Agent Number:

Requested Effective Date:

Date Signed: