

NATIONAL ASSOCIATION FOR MEDICAL & DENTAL, INC.

Membership Enrollment Form - NA245D

Last Name:		First Name:		M.I.:	Social Security Number:	
Home Address:			City (Complete Name):		State:	Zip Code:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth: Month Day Year		Home Phone: () ()		Work Phone: () ()
Email:		Spouse/Child		Male/Female	Last Name	First Name
						M.I.
						Date of Birth

Please select your payment option (annual or monthly) and provide the necessary information.

Monthly Payment - Draft Date (choose one): <input type="checkbox"/> 1st <input type="checkbox"/> 10th <i>of each month.</i>	
By Automatic Bank Account Draft: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/> Credit Card SIC	
Bank Name:	<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover
Branch Routing Number:	<input type="checkbox"/> American Express
Account Number:	Card #: _____
	Expiration Date: _____
	Card Holder: _____
PLEASE CHECK ONE OF THE FOLLOWING 3 Digit Code _____	
<input type="checkbox"/> Subscriber Only \$39.95	<input type="checkbox"/> Subscriber and One Dependand \$57.95
<input type="checkbox"/> Subscriber and Family \$79.95	<input checked="" type="checkbox"/> One Time Enrollment Fee \$55.00 <small>(To Be Included In Check)</small>
TOTAL AMOUNT OF ENCLOSED CHECK: \$	
I UNDERSTAND THAT THE INITIAL TERM OF MY GROUP MEMBERSHIP CONTRACT IS FOR 6 MONTHS. I HEREBY AUTHORIZE HCNM, INC. TO DEBIT THE BANK ACCOUNT OR CREDIT CARD EACH MONTH AS NOTED ABOVE. I UNDERSTAND THAT THE AMOUNT OF MY MONTHLY PREMIUM WILL BE DEDUCTED FROM MY ACCOUNT.	
Signature: X	Date:

Annual Payment	
PLEASE CHECK ONE OF THE FOLLOWING	
<input type="checkbox"/> Subscriber Only \$479. ⁴²	<input type="checkbox"/> Subscriber and One Dependand \$695. ⁴²
<input type="checkbox"/> Subscriber and Family \$959. ⁴²	<input type="checkbox"/> One Time Enrollment Fee \$55.00 <small>(To Be Included In Check)</small>
TOTAL AMOUNT OF ENCLOSED CHECK: \$	
Make Checks Payable To:	
HCNM INC.	Please Fax Enrollment Form To: 407-218-8943 For Assistance Call (407) 844-4719

Enrollers Name _____ # _____

