ENROLLMENT APPLICATION

Return completed application to

Fax or Mail to: Associated Ins. Srvs 11 West Passaic St. Rochelle Pk, NJ 07662 FAX: 201 703 0045

*RATES: Monthly Benefit Coverage			
	Member Only	Member + 1	Member + Family
Rx MaxPay	☐ $14.95	☐ $19.95	☐ $23.95
*Plus a one time $20 non-refundable processing fee per Member/Family			

Member Name ______ Date Of Birth ______ Age ______ Sex ______

Social Security Number ______ Telephone Number ______

Street Address ______ City ______ State ______ Zip ______

Complete the following to cover your spouse and /or children

Spouse's Name ______ Date of Birth ______ Age ______ Sex ______

Child's Name ______ Date of Birth ______ Age ______ Sex ______

Child's Name ______ Date of Birth ______ Age ______ Sex ______

Child's Name ______ Date of Birth ______ Age ______ Sex ______

Child's Name ______ Date of Birth ______ Age ______ Sex ______

Child's Name ______ Date of Birth ______ Age ______ Sex ______

I hereby apply for membership with AmSBA (ABA), and authorize my employer to deduct from my earnings the necessary contribution, if any required by me, if applicable, or: I hereby request and authorize you to pay checks drawn on my account by AmSBA (ABA), and payable to same at the current plan rates provided there are sufficient collected fund in said account to pay the same upon presentation. This authorization is to remain in effect until AmSBA (ABA), receives written notification from me revoking the authorization.

Subscriber Signature ______ **Date** ___/___/___

☐ Payroll Deduction ☐ Monthly* * Enclose a voided check for the first month's dues & enrollment fee.

Check One: ☐ Master Card ☐ Visa ☐ American Express ☐ Discover

Card # ______ Exp Date ___/___

Amount Charged $______ Signature ______ Date ___/___/___

Rate: $ ______

Enrollment Fee*: $ 20.00

Total: $ ______

ACode: 5831