Protection PLUS Life

Guaranteed Issue Term Life

Wellness ASSOCIATION OF AMERICA
Wellness for your lifetime.

WAOA Membership w/Term Life Enrollment Form

Applicant Information

Full Name: ______________________________ Date: ____________

First *Last* *(M.I.*

Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Home Phone: ____________________ Email ____________________

Date of Birth: __________ Social Security No.: __________ Applicants Age: __________

Cell Phone# (required): ______________________________ **M** ☐ **F** ☐

Agent Name: ____________________ **Agent Code:** ____________________

WAOA PPL Plan – Coverage Section

PPL Plan Level ______________________________ Age Band __________ __________

Requested Effective Date: ____________________ Initial Payment Amount: **$** ____________________

Special Instructions: ______________________________

Acknowledgement and Signature

ALL MEMBERSHIPS REQUIRE A ONE-TIME $25.00 APPLICATION – ENROLLMENT FEE.
THIS ONE-TIME FEE IS CHARGED AT TIME OF ENROLLMENT / INITIAL PAYMENT.

To the best of my knowledge and belief, the information contained on this membership enrollment application is true and complete. By my signature below, I am applying for membership in Wellness Association of America with Protection PLUS Term Life Insurance Plan as issued and insured by Lifeshield National Insurance Company, Duncan OK. I have been advised of the participation requirements, understand and agree to the Member Terms and Conditions. I hereby acknowledge and understand that I must remain an active dues paying member of the Association to be / remain eligible for this group member benefits program. I further understand that membership benefits will not be in effect until my application for membership electronically processed and all necessary Association membership dues, fees and / or applicable benefits costs have been paid. If for any reason the membership plan is cancelled in the first 30 days of participation, all membership charges will be refunded except the non-refundable one-time $25.00 enrollment fee. Any person who, with intent to defraud or knowing that he / she is facilitating a fraud against the Association or an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. *Protection PLUS Life Membership is NOT available in all states*.

Signature: ______________________________ Date: ____________

For Process: FAX TO: (856) 246-5497 or EMAIL TO: admin@winningedgemktg.com

Protection ***PLUS*** *Life* *Payment Authorization Form*

Member Payment Method and Billing Authorization Form

Email address: ____@___________________.___________

MEMBER NAME: ______________________________________**CELL PHONE#:** ________________

☐

☐MONTHLY CREDIT/DEBIT CARD BILLING AUTHORIZATION

Card Type: **Visa** ☐ **Master Card** ☐ **AMEX** ☐ **Discover** ☐

Card Number: ____ **Exp Date:** ______________

Name of Cardholder: ___________________________________ **CVV**: ___________

Please provide billing address if different from applicants home address

Billing Address:____

City: ________________________________ **State:**_________________________ **Zip**:___________

Cardholder's Signature: ____

For Protection PLUS PLUS Membership Plan - ***B****y signature below, I hereby authorized Transparent Health Group – plan administrator on behalf of the Protection PLUS Life plans as offered through the Wellness Association of America (WAOA} to charge the designated credit card* ***or*** *debit card indicated in this authorization. I understand that this authorization will remain in effect until I cancel it in writing and agree to notify Protection PLUS Life plan administrator in writing of any changes in my designated account information or termination request of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated by my enrollment form as authorized above. I certify that I am an authorized user of this credit / debit card or bank account from which funds will be withdrawn and that I will not dispute the scheduled payments with the designated Credit Card Company or bank provided the transactions correspond to the terms indicated in this authorization. I further agree that Transparent Health Groups' electronic treatment of each draft or debit, and ALL rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any draft or debit is dishonored for any reason, Transparent Health Group will not be under any liability even though dishonor may result in the forfeiture of membership and any group insurance, benefits. I further agree that this authorization is to remain in effect until Transparent Health Group receives written notice from me of its revocation.*

This enrollment application and payment authorization are solely for the collection of information and do NOT bind participation, membership or coverage. Coverage effective dates are determined / issued based on date applicant's data is electronically processed through the Protection PLUS Life on-line sales / enrollment platform and initial payment(s) is received. All memberships subject to the Terms, Conditions and Modified Death Benefit waiting periods as detailed in the members personalized LNIC Certificate of Insurance as issued following enrollment.

For questions about billing please contact Protection PLUS Life Member Services at *1-800-478-9120.*

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