Member Enrollment Application

Value 20 Life

FOR ASSOCIATION MEMBERS ONLY

Phone: 877-697-0026

______________________________________ ______ ___ _______ ____/____/______ _________

First MI Last Name Social Security Date of Birth Male/Female

____

Address City State Zip

(___)_____ _______ (___)_____ _______ ______________________________

Work Phone Home Phone e-mail Address (Required)

Dependent Information

_____________________________ ___________ ____/____/______ _______ ________________

Last Name First Name MI Relationship Date of Birth Male/Female Social Security

_____________________________ ___________ ____/____/______ _______ ________________

Last Name First Name MI Relationship Date of Birth Male/Female Social Security

_____________________________ ___________ ____/____/______ _______ ________________

Last Name First Name MI Relationship Date of Birth Male/Female Social Security

_____________________________ ___________ ____/____/______ _______ ________________

Last Name First Name MI Relationship Date of Birth Male/Female Social Security

Life Benefits are not available to anyone who answers YES to any of the following questions.

YES / NO: Has the enrolling member or enrolling spouse or child been diagnosed as Terminally Ill? (Terminal illness is a disease that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient).
YES / NO: Is the enrolling member, spouse or child confined to a Hospital, Hospice Facility or any Assisted Living Facility?
YES / NO: Is the enrolling member unable to work a minimum of 20 hours or more per week on a regular basis?

PROGRAM – (SEE BROCHURE OR WEBSITE FOR DETAILS)	AGE	MONTHLY FEE	TOTAL
EMA Value 20 Life	18-39	Individual **$49.95** / Family **$89.95**	$
	40-74	Individual **$54.95** / Family **$94.95**	$
One time Enrollment fee			$ 25.00
Line A		**TOTAL: First Payment** *includes the one-time enrollment fee(s)*	$
All applications must be entered by the 19th day of each month (11:59pm EST) to take effect on the 1st of the following month. Recurring Draft Date is the 10th day of each month for the following month's payment.			

All New Members Must Read and Sign Below: I understand that Emergency Management Alliance, Inc. (EMA) and CalStar Financial and Insurance Services, Inc. (CALSTAR) are NOT responsible for providing or guaranteeing services or guaranteeing the quality of any product that are offered through various vendors, benefits providers, networks and Insurance Companies and have no liability for the quality of service rendered by any vendor, benefits provider, network or Insurance Company. This contract is not protected by ANY Life and Health Guaranty Association. I understand that I am enrolling in an Association and that all benefits are contingent upon being an Association Member. I understand that products and services offered by EMA and the cost for those benefits may change at any time. CALSTAR is the benefits administrator for EMA.

I have read, understand and agree to the terms and conditions of this membership as outlined on page 2 of this application. These programs should not be used to replace existing insurance or be a substitute for insurance.

MEMBER'S NAME______________________________ **MEMBER'S SIGNATURE** ______________________________DATE___/____/______

I authorize CalStar Financial and Insurance Services, Inc. to deduct periodic payments from my account as noted below for the cost of the Emergency Management Alliance membership outlined above. The current cost is indicated above, on line A under TOTAL. Notification of any change to the cost of membership will be sent via email 30 Days prior to any change. I may cancel my membership at any time by simply calling **877-697-0026**.

Payment Options: ❑ MONTHLY PAYMENT

First payment indicated on Line A above.

❑ **Credit Card:** ❑ MasterCard ❑ VISA ❑ American Express ❑ Discover

Credit Card Number ___ ___ ___ ___ / ___ ___ ___ ___/ ___ ___ ___ ___ / ___ ___ ___ ___ Exp. Date________/________

Security Code ___ ___ ___ ___ (3 Digit Code on back of most cards. 4 Digit Code on front of American Express)

❑ **Automatic Bank Draft** *(Attach a voided check)* [Routing # is 9 digits & starts with 0, 1, 2,or 3]

Routing #: ____________________________ Bank Account #: ____________________________ ❑ Checking ❑ Savings

Account Holder's Name: ______________________________ **Account Holder's Signature**: ____________________________ DATE___/____/______

Agent's Name: **Agent Code:** **Requested Effective Date:** / /