

A. PLEASE COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Applicant Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: ____/____/____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____ Day Phone: _____ Evening Phone: _____ Occupation: _____

ASSOCIATION MEMBERSHIP ENROLLMENT ACKNOWLEDGEMENT

I hereby enroll for membership in the Med Sense Guaranteed Association (MSGA). As a member of MSGA, understand that I will be able to access membership products, benefits and services. I acknowledge that member benefits are subject to change without notice. Non U.S. residents are eligible for coverage if they have had a primary residence in the U.S. for 12 consecutive months prior to the effective date of coverage

Signature: _____ Date: _____

B. COMPLETE THE FOLLOWING INFORMATION ABOUT YOUR ELIGIBLE FAMILY MEMBERS YOU WANT ENROLLED:

(To be eligible. Unmarried dependent children must be under age 19 and living with applicant. If a fulltime student eligibility is to age 25.)

Spouse's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: ____/____/____
 Child's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: ____/____/____
 Child's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: ____/____/____
 Child's Name: _____ Sex (M or F): _____ Age: _____ Date of Birth: ____/____/____

C. COMPLETE THE FOLLOWING BENEFICIARY INFORMATION FOR YOUR ACCIDENTAL DEATH & DISMEMBERMENT COVERAGE:

(If this is not answered, the benefit will automatically be paid to your estate.)

Name of Beneficiary: _____ Relationship: _____
 Name of Contingent Beneficiary: _____ Relationship: _____

D. SELECT YOUR PLAN AND MONTHLY COST * (Check One) BASIC500 PLUS750 CHOICE1000 MAX1500

<input type="checkbox"/> Individual (Must be age 18 through 64 years old)	\$ 79.50	\$149.50	\$199.50	\$259.50
<input type="checkbox"/> Individual plus one	\$173.29	\$299.50	\$399.50	\$561.84
<input type="checkbox"/> Family	\$227.65	\$399.50	\$499.50	\$699.50
Add the monthly administration fee	\$ 12.50	\$ 12.50	\$ 12.50	\$ 12.50
Add the ONE time enrollment fee	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00
TOTAL AMOUNT DUE	\$ _____	\$ _____	\$ _____	\$ _____

*Monthly cost include Med Sense Guaranteed Association, discount RX benefits and discount vision benefit fees of \$9.25 for individual, \$14.95 for individual plus one and \$19.25 for a family. These are not insurance benefits nor are they affiliated with United States Fire Insurance Company.

E. AUTHORIZATION FOR AUTOMATIC BANK DRAFT OR CREDIT CARD PAYMENT:

I am signing up for an automatic payment plan. I agree Administrative Concepts, Inc. or its authorized agent may automatically debit my bank account or Credit Card for the amount due on or after the payment date. I can cancel this automatic payment at any time by calling or writing to Administrative Concepts, Inc. or its authorized agent. I agree that Administrative Concepts, Inc. or my financial institution can cancel automatic payment for my account for any reason, at any time, with or without prior notice to me. I understand that \$25.00 will be charged for each transaction rejected for insufficient funds. I acknowledge that the origination of these debits to my account must comply with U.S. laws. I agree that this agreement remains in effect until canceled by Administrative Concepts, Inc. my financial institution or me. I have a copy of this agreement and I know I can also contact Administrative Concepts, Inc. or its agent for a copy.

COMPLETE TO PAY MONTHLY BY AUTOMATIC BANK DRAFT (Note: You must attach a voided check from your checking or savings account to this enrollment):

Print Accountholders Name: _____
 Bank Name: _____ Address: _____
 Check Number: _____ Accounting Number: _____ Routing Number: _____
 Account Class: Checking Savings Type of Account: Personal Business
 Signature of Accountholder: x _____ Date: _____

COMPLETE TO PAY MONTHLY BY CREDIT CARD: Indicate type of card: VISA MasterCard

Account Number _____ Expiration Date: ____/____/____ CCV# _____ Print Accountholders Name (As it appears on the card.) _____
 Card Holder Address _____ City _____ State _____ Zip Code _____
 x _____ Signature of Account Holder _____ Date: ____/____/____

F. AGENT INFORMATION:

COMPANY: _____ AGENT NAME: _____ CODE #: _____
 EMAIL: _____ PHONE: _____ FAX: _____
 AGENT SIGNATURE: _____ DATE: _____
 MGA/GA: Lawrence S Brodsky CODE: E102300000

Fax or Mail the completed Enrollment Form to your agent or to (if payment by monthly bank draft, include a voided check with this form.):
 Health Insurance Innovations - 218 East Bearss Ave. Ste 325, Tampa, FL 33613 - Phone (877) 376-5831 - Fax (877) 376-5832