

# Membership Form



## Benefits Association, Inc.

Last name		First name	M.I.
Address		City	State Zip
Date of birth <i>(Day/Month/Year)</i>	Social Security number		Phone number
Email address			

Membership dues are only \$12 per year!

Please mail this form along with a check for \$12, bank draft authorization form, or credit card authorization form to:

Benefits Association, Inc.  
PO Box 14067  
Jackson, MS 39236-4067

Please visit [www.benefitsassociation.com](http://www.benefitsassociation.com) for information on how to take advantage of all the benefits offered to Association members.

Signature

Date

Credit Card  
**Authorization Form**



**Benefits Association, Inc.**

**Credit Card Information** Complete the following and attach to membership form

Name as it appears on the credit card		Billing Address		
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Diners <input type="checkbox"/> Discover				
Primary Credit Card Number	Expiration Date	CSV	Amount to be charged	
_____/_____/_____/_____	____/____ Month Year	____	USD \$ _____	
<b>If you are authorizing a renewal premium please indicate name of Primary Insured and the Policy Number</b>				
Name of Primary Insured		Policy Number		
Credit cards will be debited on either the 1st of the month or the 15th of the month. A maximum of three (3) attempts will be made with each card. After the third attempt, you will have to either choose another payment method, or provide another credit/debit card. You have the option of providing a secondary card below to be charged only in the event the primary card is declined.		Secondary Credit Card Number	Expiration Date	
		_____/_____/_____/_____	____/____ Month Year	

I hereby authorize MWG Administrators to withdraw payments from the information I have provided above and by signing below I agree to the following terms for all relevant plans.

1. I understand that payments will be debited from my account based on my payment mode.
2. MWG Administrators will post insurance rates increases to my account without requiring additional authorization.
3. MWG Administrators will send notice of payment not honored.
4. Payments not honored will not be submitted a second time.
5. If a payment is not honored my insurance terminates 10 days after notice has been sent.
6. If I wish to continue my insurance after a payment is not honored, MWG Administrators must receive full payment prior to the end of that month.
7. Reinstatement is only possible within 60 days of the not honored payment after which no reinstatement is possible.
8. After two payments are not honored, reinstatement is not possible.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

# Electronic Payments Authorization Agreement



Benefits Association, Inc.

## Electronic Payment Information

Primary insured's name		Last four digits of social security number or atl ID	
Mailing address			
City		State	Zip code
Phone number		Email address	
Account holder's name		Financial institution	
City		State	Zip code
		Routing number	
		Account number	
Please debit my account			
Monthly		Quarterly	Semiannually
Annually			

I hereby authorize the Financial Institution named above to pay my monthly obligation by charging each payment to my account and to make that deduction payable to the order of MWG Administrators. I agree each payment shall be the same as if it were an instrument personally signed by me. This authorization will remain in effect until revoked by me in writing. In addition, I have the right to stop payment of a charge by timely notification to my Financial Institution prior to charging my account. I understand, however, both the Financial Institution and MWG Administrators reserve the right to terminate this payment plan (or my participation therein). By signing below I agree to the following terms:

1. I understand that payments will debit my account between the 1st through 5th of each month.
2. MWG Administrators will post insurance rate increases to my account without requiring additional authorization.
3. Payments not honored will not be submitted a second time.
4. MWG Administrators will send notice of payment not honored.
5. If a payment is not honored, my insurance terminates 15 days after notice has been sent.
6. If I wish to continue my insurance after a payment is not honored, MWG Administrators, prior to the end of that month, must receive full payment.
7. If I wish to continue my insurance after a payment is not honored, MWG Administrators will charge a \$30 fee in addition to any bank charges.
8. Reinstatement is only possible within 60 days of the not honored payment.
9. After two (2) payments are not honored, reinstatement is not possible.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

Please return this authorization form and a VOIDED CHECK to:

MWG International  
ACH Enrollment • P.O. Box 14067 • Jackson, MS 39236

**Draft cannot be processed without a VOIDED ORIGINAL CHECK. Deposits slips are NOT acceptable!**