



UCAA membership including
Limited Medical Indemnity Benefits

Effective Date:
For office use only

For service, call (888) 633-5080

Titanium Series (NC Residents)

Association Membership Enrollment Acknowledgement:

I hereby acknowledge and understand that I am accepting enrollment for the membership in the United Consumer Awareness Association (UCAA). As a member of UCAA, I understand that:

- a) I will be able to access membership products, benefits and services including but not limited to UCAA awareness benefits, consumer savings programs and Limited Medical benefits.
- b) That member benefits are subject to change; and
- c) UCAA membership is available to me if I have maintained a primary residence in the United States for the past 12 months or longer. And am committed to gain awareness for a more positive consumption lifestyle.

I acknowledge that I have read and accept the terms and conditions of my association membership located in the back of this enrollment guide. I also acknowledge that upon completion of this form and submission of the initial monthly payment, I have fully accepted the terms and conditions and I also understand that benefits are provided to me based on complete information will be provided in my membership fulfillment kit.

My association membership also includes at no charge, Discount Medical Plans that are not health insurance policies and are not intended as a substitute for insurance. The plans provide for discounts on health services from participating providers, and the range of the discounts will vary depending on the type of provider and the health services received. The plans do not make payments to providers of health care services. Members are required to pay for all health care services, but will receive a discount from contracted providers. This plan is administered by Patriot Health Florida, Inc., at 160 Eileen Way, Syosset, NY, 11791 at 866-625-1836. To the best of my knowledge and belief, the information on this application is true and complete. I acknowledge that I have read and agree to the above.

Date: _____ **Signature of Applicant:** _____

ENROLLMENT FORM FOR INSURANCE TO UNITED STATES FIRE INSURANCE COMPANY

1	Member Name: _____	Social Security Number: _____	Date of Birth: _____	Gender: _____		
2	Street Address: _____	City: _____	State: _____	ZIP Code: _____		
	E-Mail Address: _____					
3	Home Phone Number: _____	Date of Enrollment: _____	Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO			
4	Beneficiary Name: _____	Relationship: _____	DOB: _____			
5	<i>Member Only</i>	<i>Member & Spouse or Child</i>	<i>Member & Family</i>			
	<input type="checkbox"/> Choice	\$139.95	<input type="checkbox"/> Choice	\$219.95	<input type="checkbox"/> Choice	\$269.95
	<input type="checkbox"/> Choice Plus	\$234.95	<input type="checkbox"/> Choice Plus	\$399.95	<input type="checkbox"/> Choice Plus	\$539.95
	<input type="checkbox"/> Elite	\$199.95	<input type="checkbox"/> Elite	\$379.95	<input type="checkbox"/> Elite	\$484.95
	<input type="checkbox"/> Elite Plus	\$299.95	<input type="checkbox"/> Elite Plus	\$529.95	<input type="checkbox"/> Elite Plus	\$709.95
	<input type="checkbox"/> Encore	\$369.95	<input type="checkbox"/> Encore	\$664.95	<input type="checkbox"/> Encore	\$929.95
	<input type="checkbox"/> Encore Plus	\$399.95	<input type="checkbox"/> Encore Plus	\$734.95	<input type="checkbox"/> Encore Plus	\$1,039.95
<input type="checkbox"/> Enrollment Fee	\$99.95	<input type="checkbox"/> Enrollment Fee	\$99.95	<input type="checkbox"/> Enrollment Fee	\$99.95	
<i>Please list all covered dependents below: The age limit for dependents is up to and including 19 years old if not a full time student, 25 years old if they are a full time student</i>						
	Name	Sex	DOB	Name	Sex	DOB
	Spouse: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	Child: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
	Child: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	Child: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
	Child: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	Child: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

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6	Credit Card: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Amex <input type="checkbox"/> Discover Card Number: _____ Exp Date ____ / ____ / ____ CCV#: _____ ACH: Routing #: _____ Savings/Checking account# _____
7	<input type="checkbox"/> (check here) YES, I wish to enroll in the membership package selected in Section 5 above.
8	Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other entity, files an application for insurance containing any materially false information or conceals, for the purpose of misleading or concealing any material commits a fraudulent insurance act, which is a crime.
9	Agent Name: _____ Agency Name: _____ Phone # _____

*The included Discount Medical Plans are provided by Patriot Health Florida Inc., a Discount Medical Plan Organization, administered at 160 Eileen Way, Syosset NY 11791.