

**VALUE MED PLAN (Minimum 5 employees)**

**PREMIUM BILLING AGREEMENT**

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**

**P.O. BOX 7901**

**MOUNT PROSPECT, ILLINOIS 60056**

The Employer hereby applies to United National Life Insurance Company of America (herein called UNL) to cause Applicant's premium billings to be processed in a manner consistent with the terms of this Agreement. In consideration of United National Life Insurance Company of America making this voluntary premium billing option available, the Employer hereby agrees as follows:

**Employer AGREEMENTS**

- Employer understands and agrees to honor Applicant's appointment and acknowledges receipt of a completed Applicant Billing Agreement Authorization form (U-15165A). The Employer further agrees to remit the currently listed insurance premiums identified on the Payroll Deduction Group Transmittal Statement as the "Total Monthly Billing" to UNL each month by the premium due date, along with any appropriate administrative and list billing fee. The Employer also agrees to follow all UNL billing instructions furnished by UNL to the Employer.
- Employer further understands and agrees not to seek from UNL access to any other information relating to Applicant's insurance coverage, beyond the amount of the Applicant's premium, without furnishing written permission from Applicant.
- Employer assumes no responsibility for this Premium Billing Agreement except as herein stated. The Employer assumes no responsibility for the payment of premium by any Applicant after his or her eligibility to participate in this Premium Billing Agreement ends. Employer acknowledges that this Premium Billing Agreement is only offered for the convenience of such Applicants.
- Employer or UNL upon giving 60 days written notice to the other and to each affected applicant, may terminate this Premium Billing Agreement in its entirety. Following termination of the Billing Agreement or termination of Applicant's employment with the Employer, payment to UNL of premium shall be made by Applicant directly to UNL. The Employer agrees to submit any and all deducted premium amounts for Applicant prior to the effective date of termination. The Employer will indicate on the copy of the Monthly Billing Statement the identity of any person who chooses to discontinue this Premium Billing Agreement or whose employment with the Employer has terminated and the requested Termination Date.
- Employer agrees to allow reasonable access to eligible members, on Employer premises, during regular working hours for the purpose of explaining and enrolling members.
- Employer understands and agrees that failure to remit the amount identified on the Monthly Billing Statement as "Total Monthly Billing", less the applicable premium for those persons who have chosen to discontinue the Premium Billing option, will result in all coverage lapsing at the expiration of the period for which premium has been properly paid.
- Employer understands and agrees that UNL may either cease this Premium Billing Agreement or adjust or change the amount of any premium billing fees upon 30 days written notice to the Employer.

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Name of Employer Contact Person \_\_\_\_\_ Name of Employer \_\_\_\_\_

Business Address \_\_\_\_\_ City & State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature of Officer/Owner \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Business Phone Number FAX Number

Producer/Agent \_\_\_\_\_ City & State \_\_\_\_\_ Zip Code \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_ Premium Due Date: \_\_\_\_\_

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_  
 (City, State) (Date) (Month) (Year)

**This form must be completed and submitted with all payroll deduction groups.**

(A) Two copies required. Original to Employer, second copy to UNL.

(B) The form designated as U-15165A (Applicant's Billing Agreement Authorization form) must be completed and signed by each applicant.

VALUE MED PLAN (Minimum 5 employees)

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA  
APPLICANT(S) BILLING AGREEMENT AUTHORIZATION FORM

New Billing Account     Addition to Billing Account # \_\_\_\_\_

I hereby appoint and authorize the following Employer \_\_\_\_\_  
to deduct my insurance premium, including administrative and list billing fee, if any, from my compensation and remit them to United National Life Insurance Company of America (UNL). I understand that my current premium amount may be adjusted in the future.

I further acknowledge that UNL will have no obligation to provide coverage, nor any other liability in the event of lapse in coverage due to the Employer's failure to remit premiums in a timely manner. I understand that I may voluntarily discontinue participation in this Billing Agreement by requesting the Employer to cease making premium payments for my insurance. Following termination of this Billing Agreement, or termination of employment with the captioned Employer, UNL agrees to bill me at the address contained in UNL's records, unless UNL receives written notification, signed by me canceling my insurance. I understand and agree that the billing statement for each applicant will only be sent to the Employer.

If you have any questions regarding this Billing Agreement, please contact: United National Life Insurance Company of America, P.O. Box 7901, Mount Prospect, IL 60056 Phone #: (847) 803-5252

(Please complete the following)

\_\_\_\_\_  
Applicant Name (Print)

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Applicant Address

\_\_\_\_\_  
City                      State                      Zip Code

( ) \_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Date



# VALUE BENEFITS OF AMERICA CLASSIC\*

## MEMBERSHIP ENROLLMENT FORM FOR LIST BILL

Member (Employer) Name: \_\_\_\_\_

I agree to the Value Benefits of America terms and conditions as listed on this form.

X \_\_\_\_\_

Signature of Primary Member

\_\_\_\_\_ Date Signed

### About Value Benefits of America Classic Membership:

Classic Benefits include over 400 major chains on-line in over 50 shopping categories, including everything from major department stores to specialty retailers to boutiques. In addition to earning rewards up to 25% shopping at participating on-line merchants, you can also receive point of sale discounts up to 50% from leading national retailers. Point of sale discounts are available on brand name merchandise, travel services and entertainment, including savings on movie tickets, movie rentals and at theme parks nationwide. You'll also enjoy savings of up to 60% dining at fine restaurants nationwide with discounted dining certificates, and the savings don't stop there. Included at no charge are discounts at over 55,000 pharmacies for your prescription drugs as well as lab tests and x-ray imaging services. Complete details of membership benefits are provided at [www.VBAmembers.com](http://www.VBAmembers.com).

### Membership Cost is \$5 per month for each member / or employee enrolling.

\*Classic Membership does not include Accident Medical, Emergency Air Ambulance or Accidental Death & Dismemberment Benefits.

### VBA Terms and Conditions:

1. Member understands that VBA is not an insurance company or program. Accident Benefit Payments are made by the administrator for the insurance company issuing the blanket coverage to Members.
2. VBA provides savings to its members on services through a number of sources. The current list of benefits may be modified through additions or deletions. A quarterly newsletter, posted on our website or sent via e-mail, will keep Members up to date on benefits and other pertinent information.
3. Payments for the VBA Program are due in advance. Payments will be drafted on or about 15 days before the due date. If you choose to cancel your program, it is your responsibility to make sure that your membership card and a written request for cancellation are sent to VBA at least 15 days prior to the anniversary of your effective date in order for your account not to be charged for additional fees.
4. Member hereby appoints, Value Benefits of America Association (VBA) President, or failing this person, a VBA Director, as proxy holder for and on behalf of the member with the power of substitution to attend, act and vote for and on behalf of the member in respect of all matters that may properly come before the meeting of the members of VBA and at every adjournment thereof, to the same extent and with the same powers as if the undersigned member were present at the said meeting, or any adjournment thereof. Annual meetings are to be held in Arizona the second Tuesday of August.
5. VBA reserves the right to terminate any enrollment or deny eligibility in the program for lack of payment to VBA. Returned checks, insufficient notices on bank drafts or denial by the member's credit card company for payment of the membership fee is deemed to be evidence of non-payment by a member. There will be a \$10.00 charge to be reinstated in the program after such denial. If reinstatement for non-payment happens more than once, a \$20.00 reinstatement will apply.
6. In the event of any dispute, member agrees to resolve said dispute solely by binding arbitration that shall be governed by the laws of the state of Arizona and enforceable at Scottsdale, Maricopa County.
7. Membership cancelled within the first 30 days of the enrollment date may be eligible for refund if the membership card and written cancellation request are sent to VBA. The administrative fee is not refundable. Approved refunds will be processed approximately 30 days after cancellation.
8. Membership is effective on the 1st of the month following enrollment acceptance by VBA.

**Member Agreement:** By signing the enrollment form, Member expresses desire to become a member of Value Benefits of America. Member acknowledges that the discount plans ARE NOT INSURANCE, but membership may include certain limited supplemental insured coverage's. Membership benefits are not a replacement for health insurance coverage nor are they intended as a substitute for health insurance coverage. Membership fees may be changed for all members, but not individually, with notification.