

PAYMENT METHOD—Checking Account Automatic Deduction For:

Initial monthly Fee and 1-Time Association processing fee (\$40.00)

Monthly Membership Fee payment

Name of Bank or Financial Institution: _____

Account No.: _____ Bank Routing No: _____

Submit one (1)-month's fees, the initial processing fee (\$40.00) and a blank check marked "Void". The monthly fee for your membership will be deducted from your checking account. If the account listed below is a joint account, both account holders' signatures are required.

Monthly Checking Account Deduction Authorization — As a convenience to me, I request and authorize you to pay and charge to my checking account amounts drawn on that account by and payable to the order of The Consumer Driven Benefits Association , or WIMG Inc. provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check personally written to you and signed personally by me. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of benefits. NOTE: Should your withdrawal not be honored by your bank, you will automatically be suspended from receiving any benefits of the Association including the special discount pricing on your medical treatment and you may incur a \$25 service charge for any withdrawal not honored.

Print Primary Member's Name: _____

Print Primary Member's Spouse's Name: _____

Authorized Signature Member
(As it appears in the financial institution's records)

Date

Authorized Signature Spouse
(As it appears in the financial institution's records)

Date

I understand that enrollment into the Consumer Driven Benefits Association entitles myself and all eligible dependents the benefits of my membership and group level in the Association...including enrollment into the Group Blanket Guaranteed to Issue Supplemental Health Insurance policies of the Association. I acknowledge that the Association's medical discount benefits for access to discounted health care benefits is not an insurance policy and are included in my membership benefits at no additional cost. By presenting my membership ID card to other ancillary healthcare providers, I will receive a discounted savings off of the provider's regular fee by accessing a negotiated fee schedule. Actual savings may vary depending on the nature of the service rendered.

The Association will make no payments to medical or health care providers. I understand that in order to receive the plan savings, I must use participating providers and pay the providers promptly for all services received. I agree to the Members Terms and Conditions on page 4 of this application and a copy of the Member's terms and Conditions will be in my Guide to Member's Benefits booklet. I also understand that my local Representative, the Association, nor the participating provider of the medical discount plan is responsible for the outcome of the medical care needed or the cost of that care.