

ACCIDENTAL TEMPORARY TOTAL DISABILITY

MEMBERSHIP APPLICATION



Last Name	First Name	Sex	Date of Birth
Address		Phone #	E-Mail Address
City	State	Zip Code	Social Security #
Spouse (if included)		Sex	Date of Birth

Name/Number of Local Chapter or Group

Chapter Name

This plan is NOT AVAILABLE to residents of Arkansas, Kansas, Idaho, Maine, Maryland, North Carolina, Oregon, South Dakota, Utah or Washington.

Check Off Your Choices			
Choose Single or Joint	Mode	<input type="checkbox"/> Single	<input type="checkbox"/> Joint
Flat \$500 per Week ATTD Benefit 52 Week Maximum	Monthly	<input type="checkbox"/> \$26.50	<input type="checkbox"/> \$53.00
Up to \$750 per Week ATTD Benefit 52 Week Maximum	Monthly	<input type="checkbox"/> \$32.00	<input type="checkbox"/> \$64.00
Up to \$1000 per Week ATTD Benefit 52 Week Maximum	Monthly	<input type="checkbox"/> \$37.25	<input type="checkbox"/> \$74.50

Payment Option

Check-ACH Credit Card

Payment Mode

MONTHLY-ACH or CC
(ACH Attach Void Check)

Make Check Payable to: WBA

Choose Modal Dues - Complete

+ **\$10.00** =
 Base Rate One Time Fee Initial Payment

Credit Card Information

VISA MC DISCOVER AMEX

Card Number Expiration (Mo/Yr)

Name on Credit Card

I hereby apply for membership with WBA and I authorize WBA and/or its authorized agent to charge my credit card for all future renewal payments as they come due, or; I hereby request and authorize you to pay checks drawn on my account by WBA and/or its authorized agent and payable to same provided there are sufficient collected funds in said account to pay the same upon presentation, or; I authorize my employer to deduct from my earnings the required contribution. **This authorization shall remain in effect until WBA receives written notification from me revoking the authorization. I will notify WBA in writing of my wish to cancel the membership 30 days in advance.**

Member Signature Date

Producer Name Producer #