AMERICAN SMALL BUSINESS DEVELOPMENT ASSOCIATION

A.S.B.D.A.
American Small Business Development Association

Single Membership - $9/Month
Family Membership - $13/Month

One-Time Association
Administrative Fee - $5.00

1 Last Name _____ First Name _____

2 Business Name _____

Address Home _____

City _____ State _____ ZIP _____

Phone _____ Date of Birth (mm/dd/year) _____ Gender ☐ M ☐ F

Email Address _____

3 Spouse (if covered) Last Name _____ First Name _____ Date of Birth (mm/dd/year) _____ Gender ☐ M ☐ F

4 Child (if covered) Last Name _____ First Name _____ Date of Birth (mm/dd/year) _____ Gender ☐ M ☐ F

5 Child (if covered) Last Name _____ First Name _____ Date of Birth (mm/dd/year) _____ Gender ☐ M ☐ F

6 Child (if covered) Last Name _____ First Name _____ Date of Birth (mm/dd/year) _____ Gender ☐ M ☐ F

Please provide the following optional information:

Association Membership

I wish to apply for membership in the ASBDA (American Small Business Development Association.) I understand that my membership allows me extra benefits independent of those provided by any insurance company. All information collected by the Field Service Representative in connection with this application for Association Membership is utilized solely for the purpose of providing Association benefits. Should I choose to cancel my Association membership, I understand I must contact the Association in writing. I understand the $50.00 (one time fee) is non-refundable.

X _____ Date (mm/dd/year) _____
Member Signature

X _____ _____ _____
Field Service Rep. Signature Print FSR Last Name, First Initial FSR Number

Please select payment option:

☐ Draft Select the date (01-28) of your draft ☐☐

☐ Enclosed check payable to ASBDA ☐ Monthly - $55/65

Automatic Bank Draft: Complete the information below and remit first payment
Automatic Payment Authorization for the purpose of honoring charges initiated by:
THE AMERICAN SMALL BUSINESS DEVELOPMENT ASSOCIATION (ASBDA),
4904 Highland Rd, Waterford Twp. Michigan 48328

I authorize above named company to debit entries to my account with the depository named below:

Bank Name _____ ☐ Checking ☐ Savings

City _____ State _____ ZIP _____ Total Monthly Draft _____

Transit/Routing Number _____ Account Number _____

Group Dental Enrollment: ____Yes____No____Family $13.00____ Individual $8.00____Alliance____

Other____ ACCESS $5.00____ : TOTAL AMOUNT DRAFTED EACH _____ Monthly

This authorization will remain in effect until the company has received notification from me that it is to be terminated in such time and manner for the company to act on it. I have the right to stop payment of a debit entry by notification to Depository at such time as to afford Depository a reasonable opportunity to act on it prior to charging account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by Depository, provided I send written notice of such debit entry in error to Depository within 15 days following issuance of the account statement of 45 days after posting whichever comes first.

X _____ Date (mm/dd/year) _____
Member Signature

THIS IS A DISCOUNT PLAN AND NOT INSURANCE