



ACTIVATION FORM ***NATIONAL***

Club Name _____

Physical Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Contact name: _____ **Title** _____

Club Phone # _____ **Club fax #** _____

Email _____ **Cell #** _____

Web site address: _____

Amenities of the club: _____

Processing Options: Choose one

Option A - Reimbursements are disbursed to the **member**.

Option B - Reimbursements are directly disbursed to the **club**.

Indemnification: By its signature below, the above Club ("Indemnitor" agrees to indemnify and hold the NIHCA and participating HMO's ("Indemnitees") harmless with respect to any claims or actions instituted by third parties that result from the use of Indemnitor's services or facilities, including any claims for death, personal injury or property damage, deceptive trade practices, or the use or misuse of information provided by Indemnitees.

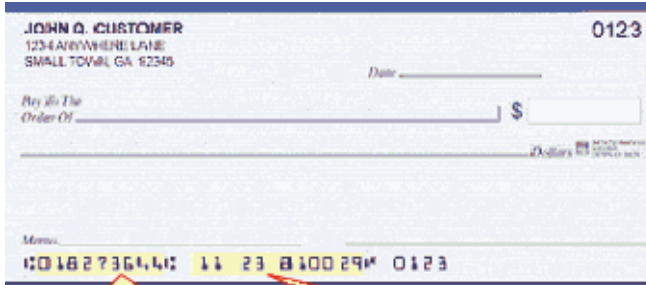
Signature of Above Named Club _____ **Date** _____

Fax to 651.554.9935
400 10th St. NW Ste #229, New Brighton, MN 55112
Ph. 866.484.9173 or 651.554.9416



PAYMENT INFORMATION
\$99 NATIONAL ANNUAL FEE
\$399 MN AND ND ANNUAL FEE

PREFERRED: ACH (AUTOMATED CHECK)



Routing Number
018273644

Account Number
11 23 810029

Account Holder's Name: _____

Routing Number: _____

Account Number: _____

Amount: (\$99 or \$399 annually)
\$ _____

I herby authorize this one-time payment to NIHCA.

Signature: _____ Date: _____

CREDIT CARD

Amount \$ _____ (amount due: **\$99 or \$399 annually**)

(Circle one): **Visa** **MasterCard**

Card number: _____

Expiration: ___/___ CVV# ___ (3 digit # on back of card)

Name on card _____

The mailing address assigned to this card: _____

I herby authorize this one-time payment to NIHCA.

Signature: _____ Date: _____

A service fee of \$10 will be charged for any billing errors that are a result of (1) Inaccurate billing information provided by the client, (2) Payment being declined due to insufficient funds.