

National Drivers Association

111 East Main Street
Delphi, IN 46923
765-564-3894

NDA BENEFITS ENROLLMENT

PLEASE PRINT OR TYPE

Member's Name: _____ E-mail _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Please check the appropriate box below to enroll in the **National Drivers Association** and begin receiving the benefits of your choice. See the benefits brochure and comparison chart for complete details on each plan. Please note that for the **Gold** plan you will need to complete a separate application for your **Accidental Death & Dismemberment** coverage to be activated. For all three plans you will need to fill out a separate application for the **Fleet One discount fuel card**.

CHOOSE YOUR PLAN

- Sign me up for the **Gold** plan to add **\$50,000 Accidental Death & Dismemberment** insurance, **Trucker's Roadside Assistance, Trucker Therapy discounts**, access to the Fleet One discount fuel card and other discounts for **only \$10** a month.
- Sign me up for the **Silver** plan to add **Trucker's Roadside Assistance, Trucker Therapy discounts** and give me access to the **Fleet One discount fuel card** and other benefits for **only \$5** a month.
- Sign me up for the Basic plan for \$2 a month. I understand that I will NOT have access to the Trucker's Roadside Assistance Program, Trucker Therapy discounts or \$50,000 AD&D Coverage.

Applicant's Signature: _____ Date: _____

AGENT INFORMATION

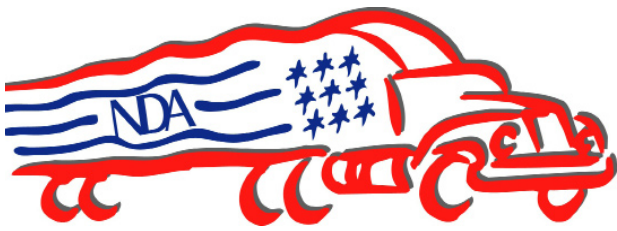
Agency: _____

Contact: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____



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ACCIDENTAL DEATH & DISMEMBERMENT APPLICATION

PLEASE PRINT OR TYPE

Member's Name: _____ E-mail _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Additional coverage for immediate family:

\$10,000 AD&D - Child @ \$3 per month per child \$50,000 AD&D - Spouse @ \$3 per month

Family members (for additional names use other side):

Name of Insured	Relationship to Member	Date of Birth

Name Of Beneficiaries (for additional names use other side):

Name of Insured	Name of Beneficiary	Relationship to Insured	Date of Birth (Beneficiary)

Applicant's Signature: _____ Date: _____

AGENT INFORMATION

Agency: _____

Contact: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____