

Enrollment Form
2009-2010 NORTH AMERICAN FOR LIFE AND HEALTH INSURANCE
ERRORS AND OMISSIONS PLAN

Please enroll me in the Error & Omissions (E&O) Program for agents of North American Company for Life and Health Insurance. Enclosed is my payment for professional liability coverage for policy period of November 1, 2009 to November 1, 2010. **Complete this form and return with your payment to: Affinity/Agents, P.O. Box 19318, Newark, NJ 07195-0318. If you elect to pay with a credit card you may fax your enrollment form to (877) 443-9183.**

1. Agent Information (Please Complete):

Agent's Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Agent #: _____ SSN: _____
 Telephone #: _____ Fax #: _____

2. You have a choice of three payment options (check one):

1. Payment in full by check. **Check is made payable to: Affinity Insurance Services, Inc.**
2. Payment by Pre-Authorized Checking (PAC) Account deductions. If choosing this method, please complete the attached PAC form **and** remit with the down payment amount listed below. Deductions from your account will begin the 3rd month following your effective date and continue until the end of the policy period.
3. Payment by **credit card** (Visa/MasterCard/Discover/American Express)
 If you choose this method, please complete the following:
(If no election is made payment in full will be the default method of payment.)
 Payment in Full Down Payment – Completed PAC Authorization Form is required.

Credit Card #: _____

Expiration Date: ____/____/____ Cardholder's Signature: _____

3. Rate & Coverage Options - Please Select Your Coverage Option and Effective Date:

Effective Date of Coverage:	Annual Rate 1M/1M*	1 M/1M PAC Down Payment	1M/1M PAC Monthly Deduction	Annual Rate 1M/2M*	1 M/2M PAC Down Payment	1M/2M PAC Monthly Deduction
<input type="checkbox"/> November 2009	\$ 828	\$183.83	\$ 64.42	\$ 873	\$ 191.33	\$68.17
<input type="checkbox"/> December 2009	\$ 764	\$183.83	\$ 64.42	\$ 805	\$ 191.33	\$68.17
<input type="checkbox"/> January 2010	\$ 699	\$183.83	\$ 64.42	\$ 737	\$ 191.33	\$68.17
<input type="checkbox"/> February 2010	\$ 635	\$183.83	\$ 64.42	\$ 669	\$ 191.33	\$68.17
<input type="checkbox"/> March 2010	\$ 570	\$183.83	\$ 64.42	\$ 600	\$ 191.33	\$68.17
<input type="checkbox"/> April 2010	\$ 506	\$183.83	\$ 64.42	\$ 532	\$ 191.33	\$68.17
<input type="checkbox"/> May 2010	\$ 442	N/A	N/A	\$ 464	N/A	N/A
<input type="checkbox"/> June 2010	\$ 377	N/A	N/A	\$ 396	N/A	N/A
<input type="checkbox"/> July 2010	\$ 313	N/A	N/A	\$ 328	N/A	N/A
<input type="checkbox"/> August 2010	\$ 248	N/A	N/A	\$ 260	N/A	N/A
<input type="checkbox"/> September 2010	\$ 184	N/A	N/A	\$ 191	N/A	N/A
<input type="checkbox"/> October 2010	\$ 119	N/A	N/A	\$ 123	N/A	N/A

* Includes a \$55 administration fee

I understand and acknowledge I am not eligible for coverage under the North American Company for Life and Health Insurance sponsored errors and omissions program unless I am legally contracted to represent North American Company for Life and Health Insurance and its covered affiliates as of my coverage effective date. I understand if my contract to represent North American Company for Life and Health Insurance or its covered affiliates is terminated, coverage under this program terminates on the same day and I am still responsible for the payment of the full annual rate. All payments are fully earned under this program and there will be no refund. I authorize Affinity Insurance Services, Inc. to process my enrollment. Your submission of this form and/or our preliminary acceptance of payment does not guarantee coverage. Should this submission be determined ineligible for coverage, your payment will be refunded.

Signature: _____ Date: ____/____/____

PAC Authorization Form
Authorization Agreement for Pre-Authorized Payments (Debits)

North American Company Sponsored Errors and Omission Program

Instructions: This form is to be used only if electing the preauthorized checking payment option. Please complete the three sections below.

I (we) hereby authorize Affinity Insurance Services, Inc. to initiate electronic debit entries or effect a charge by any other commercially accepted method, to my (our) checking account indicated below. I (we) hereby authorize the financial institution named below, hereinafter called Depository to debit the same to such account.

I (we) agree that if payments are not paid as due under the policy, as in the event withdrawals are dishonored, your coverage as an enrollee under the policy will terminate. I (we) also agree that a \$20 service charge will apply for all payments, which are returned from your banking institution.

1.
Name of Financial Institution: _____
Address or Branch: _____
City: _____ State: _____ Zip Code: _____
Transit / ABA Number: _____ Account Number: _____

The checking account must be owned by the certificate holder listed on the enrollment or renewal form. We will not honor any requests to terminate bank drafts from any person or entity other than the certificate holder.

This authority is to remain in full force and effect until Affinity Insurance Services, Inc. has collected the full annual payment, or received written notification from me (or either of us) of its termination in such time and in such manner as to afford Affinity Insurance Services and Financial Institution a reasonable opportunity to act on it. We must be notified within 48 hours of the intended deduction. Deductions are scheduled for the 1st business banking day.

2.
Name: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
(If account requires two signatures)

3. Please attach a voided check, or photocopy thereof applicable to the above account in this space.