P.O. Box 70322
Oakland, CA 94612

P : 877.248.7098
F : 888.702.6313
www.amazingcarenetwork.com

HOW TO SET-UP AN AMAZING CARE NETWORK ACCOUNT:

HOW TO SET-UP AN AMAZING CARE NETWORK ACCOUNT:

1.Have your network leader, give you their name,network name & network waived for monthly accounts with a balance greater than $1,000.

2.Calculate the monthly contribution that fits your needs. minimum contribution is $25.

3.Each accountholder must then...

a.Complete individual application form by mail or enroll online.

b.Complete beneficiary designation form.

c.Complete ACH authorization.

4.Submit original completed forms with a check or ACH authorization for the contribution ammount and fees(minimum ammount required to set up an account is $25+one time $10 set-up+minumum required two months maintenance fees(2*$5=$10) to Amazing care network.

5.A "wet signature" is required on the enrollment forms(original required). Facsimile copies are not acceptable. please enroll online at www.amazingcarenetwork.com or mail forms to:

Amazing care Network
P.O.BOX 70322
Oakland, CA 94612.

ACN
Amazing CARE Network

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AMAZING CARE NETWORK ACCOUNT APPLICATION

1. Information About You

Please print clearly. All fields are required

ACCOUNTHOLDER NAME	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ M.I. _____ Last Name _____	
MAILING ADDRESS	Address _____ City _____ state _____ Zip _____	
CONTACT INFO	Telephone Number _____ Email Address _____	
SOCIAL SECURITY NUMBER	**DATE OF BIRTH**	**DRIVER'S LICENSE / PASSPORT** or other Government issued identification.
		☐ Driver's License ☐ Passport ☐ Other _____

2. Information About Your Spouse

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
☐ Male ☐ Female First Name _____ Last Name _____	____ ____ ____	

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3.YOUR NETWORK INFORMATION

NAME OF YOUR NETWORK LEADER	NETWORK INFORMATION
If none - enter N/A	_____ Network Name _____ Network Number

4.INITIAL CONTRIBUTION AND SERVICE FEES

Please print clearly. All fields are required

INITIAL CONTRIBUTION	Minimum $25 initial contribution	$
MONTHLY CONTRIBUTION	Minimum $25 monthly contribution if balance<$1000	$
ACCOUNT SET-UP CHARGE	$10.00 one-time set-up fee	$
MONTHLY FEES	$5 / Month x 2 Months = $10	$
TOTAL AMOUNT	Amount due to open my account is being: ☐ paid by an attached check to Amazing Care Network ☐ paid via EFT. Please attach a voided check *please note that a minimum $20 balance must be kept in the account at all times.*	$

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5.ACKNOWLEDGEMENT / CUSTODIAL AGREEMENT

Required

This Application Form, When signed by me and accepted by Amazing Care Network acknowledges my receipt of the Administrative Agreement and the Custodial Agreement. I agree to be bound by the terms and conditions of the Custodial Agreement that may be amended from time to time. I further agree that I will be bound by any conditions or limitations regarding my Custodial Account established by Sterling Administration. By signing this Application Form, I consent to the sharing of financial and other information between me Amazing Care Network and among Amazing Care Network's various affiliates.

_____ _____

(Accountholder Signature) (Date)

Please do not fax! Original signature with payment must be received to avoid delay in processing your application.

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BENEFICIARY DESIGNATION FORM

_____

Accountholder Name

Please check one of the following options:

☐ **Initial Beneficiary Designation:** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of this account.

☐ **Replace Beneficiary(ies):** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of the account named above and hereby revoke all prior beneficiary(ies) designations, if any, made by me.

☐ **Add beneficiary(ies):** I designate the individual(s) or entity below as my primary and/ or contingent beneficiary(ies) of the above account. This list supplements, but does not replace, the beneficiary(ies) previously designated by me on the date specified. (When adding beneficiaries, if the share % of previously designated beneficiary(ies) changes, restate all beneficiary(ies) and the corresponding share % if the previous percentages are no longer correct.)

Beneficiary(ies):

The individual(s) or entity named in the below table shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary benefic iary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account.

NAME	DOB	RELATIONSHIP	SSN #	PRIMARY / CONTINGENT	%

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BENEFICIARY DESIGNATION FORM (CONTD)

Spousal Consent

Please check one of the following options.:

☐ **I am not married -** I understand that if I become married in the future. I must complete a new Beneficiary Designation Form

☐ **I am married -** I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below

I am the spouse of the above-named Accountholder. acknowledge that I have received a fair and reason-able disclosure of my spouse's property and financal obligations. I consent to the beneficiary designation(s) indicated above.

_____ _____

Signature of Spouse Date

Accountholder Authorization:

I 'understand that I may change Or add beneficiaries at any time by completing and delivering the proper form to Amazing Care Network.

_____ _____

Accountholder Signature Date

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AMAZING CARE NETWORK
AUTHORIZATION FORM

CREDIT / DEBIT AUTHORIZATION FORM

I hereby authorize Amazing Care Network to initiate entries to my checking/savings accounts at the financial institution listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. All entries are related to the accounts that I have established with Amazing Care Network Administered by Sterling Administration .This authority will remain in effect until Amazing Care Network is notified by me in writing to cancel it, in such time as to allow Amazing Care Network Administration and the financial institution named below a reasonable opportunity to act on it.

_____

(Name of Financial Institution)

_____

(Address of Financial Institution - Branch, City, State, & Zip)

_____ _____

(Signature) (Date)

_____

(Name of Authorizing Employee - PLEASE PRINT)

_____

(Address of Authorizing Employee - PLEASE PRINT)

Plan Account Number : _____

Transfer Request Date: _____
(Enter only the 1st or 15th of the month)

Set Amount: _____

or Maximum Amount: _____

Financial Institution Routing Number : _____

Checking / Savings Account Number : _____

The financial institution routing number and your account number can be found on your check or by contacting your financial institution.