



# Membership Renewal Application

## National Association of Health Underwriters, Colorado State Association of Health Underwriters and Affiliated State Chapters



Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Company: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(For legislative purposes only)

Business Address: \_\_\_\_\_

Work E-mail: \_\_\_\_\_ Home E-mail: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referred by: \_\_\_\_\_

### Membership Dues:

Please choose one or more affiliated chapters. Please designate your primary chapter if more than one is selected.

Metro Denver (MDAHU - \$25.00) - <b>\$310.00</b> _____	Front Range (FRAHU - \$20.00) - <b>\$305.00</b> _____
Northern Colorado (NCAHU - \$20.00) - <b>\$305.00</b> _____	Southern Colorado (SCAHU - \$20.00) - <b>\$305.00</b> _____
Western Rockies (WRAHU - \$30.00) - <b>\$315.00</b> _____	<b>Total (Primary chapter + each additional local chapter dues)</b> \$ _____

**NAHU (\$195.00) and CSAHU (\$90.00) dues are included in the total price.**

*(According to the IRS Regulations, 80% of the \$145.00 paid to NAHU and 76% of the \$90.00 paid to CSAHU are deductible as a normal business expenses)*

### Payment Options:

Bank Draft (drafted 12 x's annually) Method of Withdrawal - Checking Account (voided check) _____	Credit / Debit Card _____
VISA _____ MasterCard _____ American Express _____	Discover _____
Check - made payable to NAHU (a separate check is needed for each chapter joined) _____	_____

I (we) hereby authorize NAHU to initiate debit entries to my (out) account as indicated:

\_\_\_\_\_  
Name as it appears on check, credit or debit card Authorized signature

\_\_\_\_\_  
Account number Expiration date

\*By becoming a member of CSAHU, you give permission for the CSAHU office to fax or E-mail pertinent educational and legislative membership information to CSAHU and the affiliated chapters. I understand that I have the option to be removed from E-mails and faxes as I receive them and will notify the CSAHU office if I choose this option.

### Please indicate your area(s) of practice:

Individual _____	Small Group _____	Large Group _____	Carrier Rep _____	Dental _____
Managed Care _____	Fully Insured _____	Self-Funded _____	TPA _____	Life _____
Disability _____	Long Term Care _____	Medicare Supp _____	Worksite Mktg. _____	Retirement _____

\_\_\_\_\_ **Yes, I would be interested in someone contacting me about getting involved with my local chapter!**