



Membership 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 - \$30.00) - \$390.00 _____	Front Range (FRAHU - \$25.00) - \$385.00 _____
Northern Colorado (NCAHU - \$20.00) - \$380.00 _____	Southern Colorado (SCAHU - \$20.00) - \$380.00 _____
Western Rockies (WRAHU - \$30.00) - \$390.00 _____	Total (Primary chapter + each additional local chapter dues) \$ _____

NAHU (\$270.00) and CSAHU (\$90.00) dues are included in the total price.

(According to the IRS Regulations, 80% of the \$270.00 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!**