NAHU Membership Application

Last Name | First Name | Designation

Company | Title | Referral/Sponsor

Mailing Street Address | City | State | Zip

Telephone | Fax | E-Mail Address

Home Street Address (for legislative purposes) | City | State | Zip

Southwestern Indiana AHU

Local Association (see other side of this application)

Form of Payment Enclosed: **Amount:** $355

[ ] Monthly Draft (please select one) [ ] Checking Account [ ] Credit Card
[ ] Check (payable to NAHU)
[ ] Annual Credit Card (please select one) [ ] Visa [ ] MasterCard [ ] Am Ex [ ] Discover

Bankdraft / Credit Card Authorization Form:

I (we) hereby authorize NAHU to initiate debit entries to my (our) account as indicated.

- Monthly debits will equal one-twelfth of any current applicable national, state or local dues.
- (Please include a voided check from the account to be drafted, or write credit card number below)

Name (as it appears on the check or credit card) | Signature

Account Number | Expiration Date

Please Mark the Box or Boxes For The Areas of Your Practice:

Long Term Care	Disability	Managed Care	Retirement
Individual	Large Group	Small Group	Worksite Mktg.
TPA	Self Insured	Medicare Supplement	Dental

Mail To: Tina Hazelip, SWIAHU Membership Chair, Deaconess Health Plans, 350 W. Columbia #400, Evansville, IN 47710 (812) 450-2138

If you have questions, please contact Illana Maze, NAHU VP of Membership, at 703-276-3810