



# Membership Application

**Central Pennsylvania Association of Health Underwriters,  
Pennsylvania State Association of Health Underwriters and  
National Association of Health Underwriters**



Name: \_\_\_\_\_ Designation(s): \_\_\_\_\_

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

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

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

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

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

Referred by: \_\_\_\_\_ Primary Member in another chapter? \_\_\_\_\_

Membership Dues:

<u>Association</u>	<u>Monthly</u>	<u>Annual</u>
Central Pennsylvania Association of Health Underwriters (CPAHU)	\$3.30	\$40.00
Pennsylvania Association of Health Underwriters (PAHU)	\$6.67	\$80.00
National Association of Health Underwriters (NAHU)	\$22.50	\$270.00
<b>Total Dues</b>	<b>\$32.50</b>	<b>\$390.00</b>

**NAHU, PAHU and CPAHU membership is included in the total price.**

*(According to the IRS Regulations, 80% of the \$270.00 paid to NAHU is 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 \_\_\_\_\_

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

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

\_\_\_\_\_  
Bank account number or credit card number Expiration date

\*By becoming a member of CPAHU, you give permission for CPAHU to fax, E-mail or mail pertinent educational and legislative membership to you. I understand that I have the option to be removed from mail, E-mails and faxes lists as I receive them and will notify CPAHU 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!**