



Membership Application

Draft

ORGANIZATION INFORMATION

Organization Name: _____

Parent Company (if different): _____

Website Address: _____

Location #1 Mailing Address: _____

Street Address (if different): _____

City: _____ State: _____ ZIP Code: _____

Number of Employees at Address #1: _____ Number of Employees at Address #1 Enrolled in Company Insurance Plan: _____

Location #2 Mailing Address (if applicable): _____

Street Address (if different): _____

City: _____ State: _____ ZIP Code: _____

Number of Employees at Address #2: _____ Number of Employees at Address #2 Enrolled in Company Insurance Plan: _____

If applicable, attach information for each additional location, including: addresses; number of employees at each address; and number of employees enrolled in company insurance plan at each address.

Number of Employees (Nationally): _____ Total Number of Employees Enrolled in Company Insurance Plan: _____

- Legal Entity: self-employed partnership
for-profit entity: sole proprietor limited liability company limited partnership
 "s" corporation "c" corporation other _____
 non-profit rural utility cooperative trade or labor organization
municipality/public: town village city county school district

MAIN CONTACT INFORMATION

Name: _____ Title: _____

Address (if different than above): _____

Phone: _____ E-mail: _____ Fax: _____

HEALTH INSURANCE AGENT AND AGENCY INFORMATION

Name of Health Insurance Agent: _____

Name of Health Insurance Agency: _____

MEMBERSHIP FEE (NOT REFUNDABLE)

Membership Level

- 1-10 eligible local employees, \$250
- 11-49 eligible local employees, \$500
- 50+ eligible local employees, \$1,000

Payment

- Check Attached
- Check Attached
- Check Attached

SIGNATURE

Signature of applicant: _____ Date: _____

Return by _____, 2009 along with payment