

**East Texas Association of Health Underwriters
Associate Membership Application**

Name _____

Company/Agency _____

Business Address _____

City _____ TEXAS Zip Code _____

Business Telephone # _____ Fax # _____

E-mail Address _____

Home Address _____

(Confidential – needed for identifying the political districts of our members)

City _____ TEXAS Zip Code _____

Home Telephone # _____ Cell Phone # _____

Preferred Mailing Address: Business Home Referring Member _____

(Please circle one)

DUES

ETAHU Portion – Local \$ 25.00

Total \$ 25.00

Payment Methods

- Check (Please make check payable to ETAHU)
- Credit Card: MasterCard Visa Discover American Express (please circle one)

Name on Card _____

Expiration Date _____ Card Number _____

Signature _____

Amount _____

This authorization is to remain until ETAHU/ TAHU has received written notification from me of its termination. I authorize Association Headquarters to charge my credit card for the amount as shown above.

Mail completed form along with payment to:
Monika Stade, ETAHU Membership Chair
Healthcare Partners of East Texas, Inc.
426 N. Center Street
Longview, TX 75601-6403