



# NAHU Membership Application



Last Name		First Name		Designation	
Company		Title		Referral/Sponsor	
Mailing Street Address		City	State	Zip	
Telephone		Fax	Work E-Mail Address		
Home Street Address (for legislative purposes)		City	State	Zip	
Home Phone Number			Home Email Address		

Local Association (see other side of this application)

**Form of Payment Enclosed:**

Monthly Draft (please select one)

Check (payable to NAHU)

Annual Credit Card (please select one)

**Amount:** \_\_\_\_\_

Checking Account  Credit Card

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:**

<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Disability	<input type="checkbox"/> Managed Care	<input type="checkbox"/> Retirement
<input type="checkbox"/> Individual	<input type="checkbox"/> Large Group	<input type="checkbox"/> Small Group	<input type="checkbox"/> Worksite Mktg.
<input type="checkbox"/> TPA	<input type="checkbox"/> Self Insured	<input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> Dental

**Mail To: NAHU, 1212 New York Avenue NW, Suite 1100, Washington, DC 20005**

**Fax to: 202-747-6882**

*If you wish to donate to HUPAC, please send your donation to:*

**HUPAC**

**PO Box 20897**

**Indianapolis, IN 46220**

**or online at [www.hupac.org](http://www.hupac.org)**

**If you have questions, please contact Membership at 202-552-5060 or [membership@nahu.org](mailto:membership@nahu.org)**