CFAHU 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: **Central Florida Association of Health Underwriters**

Form of Payment Enclosed: **Amount:** _____

☐ Monthly Draft (please select one) $44.16 ☐ Checking Account ☐ Credit Card
☐ Check (payable to NAHU) $530
☐ Annual Credit Card (please select one) $530 ☐ Visa ☐ MasterCard ☐ American Express ☐ 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 Plans
☐ Large Group ☐ Small Group ☐ Worksite Mktg. ☐ TPA ☐ Self Insured
☐ Medicare ☐ Dental

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