

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) \$45.17

Checking Account

Credit Card

Check (payable to NAHU) \$542

Annual Credit Card (please select one) \$542

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

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

HUPAC

1212 New York Ave, NW Suite 1100


Washington, DC 20005 or online at www.hupac.org

Mail To: FAHU

PO Box 150358

Altamonte Springs, FL 32715-0358

Fax/email to: 407-831-2990/fahu@fahu.org

 (407) 831-50000

 info@cfahu.org

 www.cfahu.org

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