



**PCAHU / FAHU / NAHU
Membership Application**



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

Palm Coast Association of Health Underwriters
Local Association (see other side of this application)

Form of Payment Enclosed: **Amount: \$385 / 12months = \$32.08 if paid monthly**

- Monthly Draft (please select one) Checking Account Credit Card
 Check (payable to NAHU)
 Annual Credit Card (please select one) 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

Email completed form to: membership@pcahu.org, or if paying by check, please hand deliver to PCAHU Membership Chair. If you have questions, please contact PCAHU's Membership committee at membership@pcahu.org or our information line at info@pcahu.org.

WE LOOK FORWARD TO YOUR MEMBERSHIP WITH PCAHU !

