

Application for Membership

Company or Organization: _____

Designated Representative: _____
Name Title

Address: _____

Telephone: () _____ **Fax:** () _____ **Email:** _____

<i>Class of Membership</i>	<i>Dues Structure</i>
_____ State Self-Insurers Association	\$6.00 per member
_____ Individual Self-Insured Company	
Over 10,000 employees.....	\$600.00
5,000 – 9,999.....	\$500.00
3,000 – 4,999.....	\$400.00
Under 3,000.....	\$300.00
_____ Group Self-Insurer	\$475.00
_____ State Self-Insurance Guaranty Fund	\$475.00
_____ Professional Member Serving Self-Insurers	\$500.00
_____ Attorney	
_____ Service Company or Agency	
_____ Other Brief description of services: _____	

For additional persons within your organization to receive notices and mailings (\$50.00 each):

Name: _____ **Title:** _____

Address: _____ **Email:** _____

Payable by Check or Charge:

_____ Please find enclosed a Check payable to National Council of Self Insurers in the amount of \$ _____

_____ Please charge the amount of \$ _____ to the following:

() Visa () MasterCard () American Express

Credit Card Number: _____ **Exp. Date:** _____ **CSV** _____

Card in the Name of: _____

Billing Address _____

Signature: _____