

**HOUSTON CLAIMS ASSOCIATION**

P. O. Box 472  
Alief, TX 77411-0472  
(281) 933-4028

**ASSOCIATE MEMBER APPLICATION**

(Please Type or Print)

ANNUAL DUES \$50.00

NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_

POSITION \_\_\_\_\_

PREFERRED MAILING ADDRESS \_\_\_\_\_  
\_\_\_\_\_

PHONE: OFFICE \_\_\_\_\_ FAX \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

I understand that providing an email address and my signature below will comply with the "opt in" segment of the CAN-SPAM Act of 2003 and I will receive the HCA newsletter by email.

**TYPES OF SERVICES PROVIDED/CLAIMS HANDLED**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**NAME THREE (3) BUSINESS REFERENCES (at least one must be a present member of the Association)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I agree that the above information is all true and correct, that I am an individual associated with or providing services to the insurance industry, realizing any facts falsely given could mean rejection of the application for membership in the HOUSTON CLAIMS ASSOCIATION.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**FOR EXECUTIVE COMMITTEE USE ONLY**

Date Approved: \_\_\_\_\_

Rejected/Reason: \_\_\_\_\_