

HOUSTON CLAIMS ASSOCIATION

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

ASSOCIATE MEMBER APPLICATION

(Please Type or Print)

ANNUAL DUES \$60.00 (Cash/Check) \$62.50 (On-line)

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: _____