



Membership Application

1. Contact Information

Name		Title	
Company Name			
Street Address			
City	State	Zip Code	
Business Phone	Fax	Cell Phone (optional)	
Email Address		Website	

2. Please select membership type

Membership Type	Description	Please Select One
\$25.00 General Membership	Insurance Related Employment	
\$30.00 Associate Membership	Insurance Support Employment	

3. Payment*

Check	Please make checks payable to: Cleveland Claims Association
Paypal	Paypal payments will NOT be accepted unless accompanied by a receipt.

*Please attach check or paypal receipt to this registration form and bring to the next Cleveland Claims meeting

**If you are unable to attend the meeting, please mail to the address below.

Membership dues are collected on an annual basis and runs from September 1 through August 31 of the following year. Dues shall be payable between September 1st and December 31st.

4. Authorization to publish email address:

<input type="checkbox"/>	Please publish my email address on the Cleveland Claims website
<input type="checkbox"/>	I do not wish to have my email address published on the Cleveland Claims website

X _____
Signature Date