

National Council of Self Insurers
1253 Springfield Ave, PMB 345
New Providence, NJ 07974
(908) 665-2152; FAX: (908) 665-4020
E-mail: natcouncil@aol.com - www.natcouncil.com

Application for Membership

Date: _____

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 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 in the amount of \$ _____

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

() Visa () MasterCard () American Express

Credit Card Number: _____ Expiration Date: _____

Card in the Name of: _____

Signature: _____