



**Central California Association of Health Underwriters
STAFF MEMBERSHIP* APPLICATION**

Date: _____

Name: _____

Title: _____

Professional Designation: _____ **Insurance License #:** _____

Company/Agency: _____

Address: _____

City/State/Zip: _____

Telephone: (____) _____ - _____ **FAX:** (____) _____ - _____

E-Mail Address: _____

Home Address: _____ **Home Phone:** (____) _____ - _____

City/State/Zip: _____

My Membership Sponsor is: _____

Signature: _____

Please make your check for \$75 payable and mail to:

CCAHU Membership
PO Box 1071
Fresno, CA 93714
(800) 347-5950

**Staff membership must be a staff member of a full NAHU/CCAHU member*