

**East Texas Association of Health Underwriters  
Associate Membership Application**

Name \_\_\_\_\_

Company/Agency \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ TEXAS Zip Code \_\_\_\_\_

Business Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Home Address \_\_\_\_\_

(Confidential – needed for identifying the political districts of our members)

City \_\_\_\_\_ TEXAS Zip Code \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Preferred Mailing Address: Business Home Referring Member \_\_\_\_\_

(Please circle one)

**DUES**

**ETAHU Portion – Local      \$ 25.00**

**Total                                \$ 25.00**

Payment Methods

- Check (Please make check payable to ETAHU)
- Credit Card: MasterCard    Visa    Discover    American Express (please circle one)

Name on Card \_\_\_\_\_

Expiration Date \_\_\_\_\_ Card Number \_\_\_\_\_

Signature \_\_\_\_\_

Amount \_\_\_\_\_

This authorization is to remain until ETAHU/TAHU has received written notification from me of its termination. I authorize Association Headquarters to charge my credit card for the amount as shown above.

*Mail completed form along with payment to:*  
**Monika Stade, ETAHU Membership Chair**  
**Healthcare Partners of East Texas, Inc.**  
**426 N. Center Street**  
**Longview, TX 75601-6403**