



CAHP Associate Membership Application

Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Website: \_\_\_\_\_

Primary Contact Person (for Membership)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Assistant: \_\_\_\_\_

Assistant's phone: \_\_\_\_\_ Assistant's email: \_\_\_\_\_

Describe your organizations activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Select your Type of Membership:

Gold  \$3,000 (Includes exhibit space at conference) Join Date: \_\_\_\_\_

Silver  \$1,000 (Does not include exhibit space)

Method of Dues Payment:

Check Enclosed:  Invoice:

Please include the following enclosures with your application: (optional)

- Annual Report
- Brochure or other descriptive material

I hereby apply, on behalf of the Company named above for associate membership in the Colorado Association of Health Plans. I certify that the information provided herein is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax to: CAHP ● 1177 Grant Street, Suite 306 ● Denver, Colorado 80230. Phone 303.832.9611, Fax 303.861.9749