



Medical Alliance Association, Inc.

MEMBERSHIP INFORMATION SHEET

CONFIDENTIAL:

COMPANY NAME: _____

SPECIALITY: _____

COMPANY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OWNER: _____

CONTACT: _____ TITLE: _____

OFFICE PHONE: (____) _____ FAX: (____) _____

OTHER PHONE #'S: (____) _____ BEST TIME/CALL: _____ AM PM

POLICY NUMBER: _____

ESTIMATED ANNUAL PREMIUM (see below): _____

WEB ADDRESS: _____

EMAIL: _____

Annual Membership Fee

ANNUAL EAP	Annual Membership Fee
Up to \$1,999	No fee
\$2,000 - \$2,999	\$50
\$3,000 - \$6,999	\$75
\$7,000 - \$19,999	\$100
\$20,000 and above	\$200

Members of Group 834 receive a **free** business web site listing with your membership fee.

Do we have your permission to list your business? YES NO

Brief description of your business. Please state in 50 words or less. (If you require more space you can add this on the back of this form or attach a separate sheet)

Comments:

Please mail the completed form to:
PO Box 3556
Fremont, CA 94539-0355