



Application for Membership

Name: _____
(Last) (Initial) (First)

Company Name: _____ Principle License # _____

Designations: _____ Official Position: _____

Physical Address
 Address: _____
 City: _____ State: __ Zip: _____

Mailing Address
 Address: _____
 City: _____ State: __ Zip: _____

Company Website: _____ Email: _____

Phone Number (____) ____ - _____ Fax Number (____) ____ - _____

<u>Membership Category</u>	<u>Membership Cost</u>	
	<small>(One-time) Initiation Fee</small>	<small>+ Annual Fee</small>
<input type="checkbox"/> Agency (Independent Agent/Agency)	\$50.00	+ \$400.00
<input type="checkbox"/> Associate (Other than Agent/ Agency)	\$100.00	+ \$400.00
<input type="checkbox"/> Affiliate Membership (Agents Only Beyond 90 Miles of Closest LAAIA Chapter)	\$50.00	+ \$95.00

I/We certify that the above listed information is true and accurate and that we accept all regulations of the constitution of the Latin American Insurance Agencies.

Signature of Applicant: _____ Date: _____

Please make check payable to LAAIA.
 Kindly send application with payment to:

LAAIA
 PO Box 520844
 Miami, Florida
 33152-0844

Method of Payment

- Check
- Bill Me
- Visa
- MasterCard
- American Express

Credit Card # Exp. date

Signature