



Health Plan Membership Application

Organization Name: _____
Address: _____
Phone: _____ **Fax:** _____
Website: _____

Primary Contact Person (for Membership):

Name: _____ **Title:** _____
Phone: _____ **Fax:** _____
email: _____ **Assistant:** _____

Chief Executive Officer:

Name: _____ **Title:** _____
Phone: _____ **Fax:** _____
email: _____ **Assistant:** _____

Primary Legislative Contact:

Name: _____ **Title:** _____
Phone: _____ **Fax:** _____
email: _____ **Assistant:** _____

Primary Communications Contact:

Name: _____ **Title:** _____
Phone: _____ **Fax:** _____
email: _____ **Assistant:** _____

Describe your membership:

1. Total Membership Count: _____

2. Product Types:

HMO	
POS	<input type="checkbox"/>
PPO	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>
Medicare + Choice	<input type="checkbox"/>
Other	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

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

<input type="checkbox"/>	Annual Report
<input type="checkbox"/>	Brochure or other Descriptive Materials
<input type="checkbox"/>	

Agreement:

On submitting the MAHP Health Plan membership application, applicant agrees, if admitted to membership, to use their best efforts to advance aims and purposes of the association and to pay annual dues determined by the MAHP Board of Directors. This information is certified as true and correct.

Signature Date

Please print, sign and submit the original signed copy of this application. Thank you.

Your completed application will be reviewed at the next MAHP Board of Directors meeting. Upon acceptance, we will notify you of your admission as an MAHP Health Plan Member along with a notice for your annual dues. If you have any questions, please contact MAHP Member Support at 617.338.2244 or email info@mahp.com.

