NHCAA
National Health Care Anti-Fraud Association

1220 L Street NW
Suite 815
Washington, DC 20005

Affiliate Membership Application

Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____ Organization Website _____

Reset Section

PRIMARY CONTACT (Membership Forum Representative)

Name _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

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MEMBERSHIP CATEGORY

Membership in NHCAA as an Affiliate Member is available to companies that are engaged in the provision of insurance products that provide for the reimbursement of medical expenses or are contingent upon health conditions (including pharmacy benefit management, workers' compensation, long-term care, disability or other property or casualty insurance products that may provide reimbursement for medical expenses) and that are not otherwise eligible for membership as a Member Organization.

Product Lines (Please check all boxes below that describe your organization's insurance products):

☐ Workers' Compensation ☐ Disability ☐ Long-Term Care

☐ Personal Injury ☐ PBM ☐

☐ Other (Insurance products that may provide reimbursement for health care expenses):

_____

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ANNUAL DUES RATE: $16,550

I understand that by providing my company's mailing address, email address, and telephone and fax numbers, we consent to receive communications sent by or on behalf of the National Health Care Anti-Fraud Association (NHCAA) or The NHCAA Institute for Health Care Fraud Prevention (The NHCAA Institute) via regular mail, email, telephone, fax.

Print Name _____

Signature _____ Date _____

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RETURN THIS COMPLETED APPLICATION FORM AND PAYMENT TO:

National Health Care Anti-Fraud Association
1220 L Street, NW, Suite 815 • Washington, DC 20005