

**COMPANY CONTACT INFORMATION**

Company \_\_\_\_\_

Contact \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Fax \_\_\_\_\_

Website \_\_\_\_\_

License Jurisdictions \_\_\_\_\_

**CLAIM CONTACT (IF DIFFERENT FROM PRIMARY CONTACT)**

Name \_\_\_\_\_

Title \_\_\_\_\_

Designations:  ALHC  FLHC  Others \_\_\_\_\_

E-mail \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Fax \_\_\_\_\_

**FRAUD/SIU CONTACT**

Name \_\_\_\_\_

Designations \_\_\_\_\_

Title \_\_\_\_\_

E-mail \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Fax \_\_\_\_\_

**MEMBERSHIP DUES**

Corporate Membership (Annual Dues) .....\$2,350

How did you learn about ICA? \_\_\_\_\_

**BILLING INFORMATION**

Check enclosed for \$ \_\_\_\_\_ (Please make checks payable to ICA. Funds must be in U.S. currency drawn on a U.S. bank or credit cards only)

Credit Card: <https://claim.org/education/membership-dues/>

**MEMBER DEMOGRAPHICS**

Please complete the relevant information below.

**COMPANY TYPE:**

- BlueCross Blue Shield Organization
- Life & Health Insurer
- Managed Care Organization
- Reinsurer  Third Party Administrator
- Other \_\_\_\_\_

**PRODUCT LINE:**

- Annuities
- Disability
- Health/Medical
- Long Term Care
- Life/AD&D
- Other \_\_\_\_\_

**Please Note:** All applications for membership are subject to approval by the ICA Officers.

*I agree that I am authorized to act on behalf of the Company and that, if accepted as a member of the International Claim Association, the Company and its claim personnel will subscribe to the ICA Statement of Principles and Statement of Object and Purpose.*

\_\_\_\_\_  
**NAME**

\_\_\_\_\_  
**SIGNATURE**

Return Complete Application via email to **memberservices@claim.org**

Tax Identification #: 11-6062801

Phone: 202-452-0143

**www.claim.org**

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Suite 400 South  
Washington, DC 20036