Membership Application Form

Name:_____

Address:_____

City:_____ State:_____ ZIP:_____

Phone:_____ Email:_____

Occupation:_____

Employer:_____

Address:_____

Phone:_____ Fax:_____

I certify that the above information is true and accurate:

_____

Signature of Applicant

Proposed By: _____

Seconded: _____

*** Membership Fee of $20.00 is due, payable to the Albany Claims Association, upon submission of this form. All renewal forms should be mailed to**

Albany Claims Association

PO Box 14292

Albany, NY 12212-4292