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 c/o Alixanne Ruff

PO Box 14292

Albany, NY 12212-4292

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