



Membership Application

Date of Application: _____

Participation Effective Date: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Web Address: _____

Type of Business: _____

Name of CEO: _____

Name of CFO: _____

Primary Contact Name: _____

Title: _____ Email: _____

Phone: _____ Fax: _____

Secondary Contact Name: _____

Title: _____ Email: _____

Phone: _____ Fax: _____

Total Number of Employees: _____ Total Number of Employees _____
in Insurance Plan(s):

What employee benefit programs do you currently offer? HMO PPO POS Indemnity Vision Dental
 Wellness Program Prescription Drug Coverage

When is your renewal? _____

Is your health plan: Fully-Insured Self-Funded

Name of Insurance Carrier (s) _____

Name of TPA _____

Membership Dues Structure (select one):

2-49 Employees (\$350) 50-249 Employees (\$700) 250-499 Employees (\$1,350) 500+ Employees (\$2,000)

**Mail completed Membership Application to: Tri-State Business Group on Health
8437 Bell Oaks Drive, PMB #126
Newburgh, IN 47630**

*Membership applications are reviewed and approved by the Board of Directors at their monthly meeting.
Once approved, you will be billed for your membership dues.*