MAINE STATE CHAMBER PURCHASING ALLIANCE INC.

Please return by mail to:
Maine State Chamber Purchasing Alliance, Inc.
Attn: Member Services
125 Community Drive, Suite 101, Augusta, ME 04330-8010.
Or fax it to: (207) 622-7723.

If you have any questions,
please call Member Services at (207) 623-4568, ext 14.

Employer/Applicant and Fee Assessment Information

ASSESSMENT INFORMATION

At the time of enrollment, the Employer/Applicant is responsible for completion of this form and payment of the $50.00 annual assessment fee (please note, this is not a membership fee).

Detailed eligibility information is available on the Maine State Chamber Purchasing Alliance, Inc. Participation Agreement.

CHAMBER INFORMATION

____
Please list local/regional chamber(s) in which you are a member

Number of employees: ______________

The Maine State Chamber Purchasing Alliance, Inc. program, "CHAMBER BLUEOPTIONS," is designed to serve small businesses with 2-50 employees, as well as self-employed people, with exclusive healthcare coverage opportunities. This program is only available to you **if you are currently a member of a chamber of commerce in Maine**.

COMPANY/ORGANIZATION INFORMATION

____
Name of Company or Organization

____
Name & Title of **CEO** / **President** / **Owner** / **Principal Partner**

____
Street Address

____
Corporation, Sole Proprietorship, Partnership, LLC

____
Mailing Address If Different From Street Address

____
City, State/Province, Country, Zip

____
Web Site URL

______________ / ______________
Telephone Fax

____
Type of Business (Manufacturer, Health Care, Legal, etc.)

____
CEO Email

____
Name of Person Submitting This Application

____
Applicant's Title

____
By signing on the above line, I hereby confirm that I am authorized to enter into this agreement.

____
Date of Application

Method of Payment

- ☐ **Company check** is enclosed for the $50.00 annual assessment fee, ***payable to Maine State Chamber Purchasing Alliance, Inc. (or MSCPA, Inc.)***.
- ☐ **Please charge** the $50.00 annual assessment fee to the following credit card:

☐ **Visa** ☐ **MasterCard** **Card Number & Exp. Date**: ______________________________

****Insurance Agent/Producer - PLEASE COMPLETE – This information is for MSCPA Office use only****

Date: _____/_____/_____ Status (check one): __ New __ Renewal Effective Date of Coverage: _____/_____/_____

PRODUCER/AGENT INFORMATION:

Agency Name: ______________________________ *Producer Name:* ______________________________

Authorized Signature: ______________________ Name on Card (please print): ______________________________

FOR OFFICE USE ONLY: Please date and initial the appropriate line.

Database: ________ Finance Dept.: ________ MMS Dept.: ________ Advocacy: ________ Filed: ________

Legislative Districts: House#: ________ Senate#: ________

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