AMERICAN ACADEMY OF INSURANCE MEDICINE

2020 APPLICATION FOR MEMBERSHIP

(Please print clearly)

Last Name _____ First Name _____

Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Credentials _____

Company Position / Title _____

Company Name _____

Company Address _____ City _____

State / Prov. _____ Zip / Postal _____ Country _____

Office Telephone _____ Fax _____ Email _____

Home Address _____ City _____

State / Prov. _____ Zip / Postal _____ Country _____

Home Telephone _____ Preferred Mailings: ☐ Office ☐ Home

Medical School _____ Year of Graduation _____

What, if any is your field of specialization? _____

Member of AMA: ☐ Yes ☐ No BIM Certified: ☐ Yes ☐ No

Categories of Membership:

Active membership shall consist of physicians (MD or DO) who are medical directors, associate medical directors, assistant medical directors, or medical consultants for insurance companies. Active members shall be entitled to hold office, vote, serve on committees, make nominations and generally exercise the rights of full membership.

Associate membership shall consist of physicians (MD or DO) who are not medical directors, associate medical directors, assistant medical directors, or medical consultants of insurance companies, and nurses or other health professionals who serve in the capacity of insurance company medical directors, associate medical directors, assistant medical directors or medical consultants. They may not hold office or vote, but may be appointed to committees.

Affiliate membership shall consist of individuals who have a professional interest in insurance medicine such as paraprofessionals, underwriters, and actuaries. They may not hold office or vote, but may be appointed to committees.

Emeritus membership shall consist of former dues paying members, retired or working less than 10 hours per week as an employee or consultant for a salary or fee in the field of Insurance Medicine. He/She may not hold office or vote, but may be appointed to committees.

Membership Dues:

☐ **Active** $500.00 ☐ **Associate** $400.00 ☐ **Affiliate** $300.00 ☐ **Emeritus** $50.00

Payment Method:

☐ **Check enclosed** (Please make check out to the **American Academy of Insurance Medicine**. Check must be drawn on a US bank or be an international money order.)

☐ **Credit Card** ☐ American Express ☐ MasterCard ☐ Visa

Card Number: _____ Card Expiry: _____

CVV: _____

Cardholder Name _____ Signature _____

Cardholder Address: _____ Zip Code / Postal Code: _____

Your credit card will be charged the membership dues plus 2% credit card fee.

PLEASE SUBMIT YOUR APPLICATION FORM USING ONE OF THE OPTIONS BELOW:

Email	Mail	Fax
aaim@unconventionalplanning.com	**AAIM** 100 – 32 Colonnade Road Ottawa, ON K2E 7J6 Canada	**613-721-3581**