

Consumer Directed Benefits Association
Membership Application
And
Dues Statement

Please type or print the following information:

Last Name	First Name	Designation
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Organization	Title
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Business Address	City, State, Zip Code
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Telephone (Office)	Telephone (Mobile)	Facsimile
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E-mail Address	Organization Website
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Type of Membership: [Check all that apply.] Third Party Administrator Insurance Broker
 Insurance Agent Employee Benefits Consultant Dental Organization Representative
(Dentist) Dental Organization Representative (Staff) Other: _____

List Any Professional Credentials You Hold: _____

In Which States Are You Licensed to Operate: _____

Dues Remittance: Please complete a membership application for each person in your organization seeking membership in CDBA. The annual dues rates are:

Corporate (TPAs, Brokers, Consultants, Insurance Carriers)	\$325
Association (ADA, State, Specialty Organization, Vendor)	\$250
Individual (Dentist, Supporter)	\$55

Forward dues payments to:

Consumer Directed Benefits Association
1111 E. Tennessee St.
Tallahassee, FL 32308
Attn: Bob Macdonald

For Office Use Only

Date Received:

Check No:

Amount: