

AFFILIATE APPLICATION

Company Name: _____

Type of Industry: _____

Primary Contact

Name: _____

Title: _____

Address: _____

Phone: _____

Email: _____

Secondary Contact

Name: _____

Title: _____

Address: _____

Phone: _____

Email: _____

Copy and attach additional pages to list additional secondary contacts. All contacts will receive event invitations and communications from the coalition.

MBCH Affiliate Annual Membership Dues

Annual affiliate dues are \$5,000. Payment is due within 30 days of notification of acceptance.

Dues will be invoiced upon receipt and acceptance of application, and thereafter on the anniversary date of joining MBGH. Rates are subject to change. Payment is due within 30 days of membership acceptance.

By completing this application, I am indicating that I am authorized to commit my organization to joining the Minnesota Business Coalition on Health. I understand that my organization will be invoiced based on the dues schedule above. My organization may choose to terminate its membership at any time but is not entitled to a refund of dues paid.

Name of Authorized Individual Completing Application: _____

Title: _____

Date: _____

Signature: _____

THANK YOU FOR JOINING MBCH!

Please return this form via e-mail to:
Jean Hanvik (jhanvik@sghcomm.com)