MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

Health Plan Membership Application

Organization Name:_____
Address:_____
Phone:_____ Fax:_____
Website:_____

Primary Contact Person (for Membership):
Name:_____ Title:_____
Phone:_____ Fax:_____
email:_____ Assistant:_____

Chief Executive Officer:
Name:_____ Title:_____
Phone:_____ Fax:_____
email:_____ Assistant:_____

Primary Legislative Contact:
Name:_____ Title:_____
Phone:_____ Fax:_____
email:_____ Assistant:_____

Primary Communications Contact:
Name:_____ Title:_____
Phone:_____ Fax:_____
email:_____ Assistant:_____

Describe your membership:
1. Total Membership Count: _____

2. Product Types:
- ☐ HMO
- ☐ POS
- ☐ PPO
- ☐ Medicaid
- ☐ Medicare + Choice
- ☐ Other
- ☐
- ☐

Please include the following enclosures with you application: (optional)
- ☐ Annual Report
- ☐ Brochure or other Descriptive Materials
- ☐

Agreement:
On submitting the MAHP Health Plan membership application, applicant agrees, if admitted to membership, to use their best efforts to advance aims and purposes of the association and to pay annual dues determined by the MAHP Board of Directors. This information is certified as true and correct.

Signature Date

Please print, sign and submit the original signed copy of this application. Thank you.

Your completed application will be reviewed at the next MAHP Board of Directors meeting. Upon acceptance, we will notify you of your admission as an MAHP Health Plan Member along with a notice for your annual dues.
If you have any questions, please contact MAHP Member Support at 617.338.2244 or email info@mahp.com.