



MEDICAL MEMBER APPLICATION FORM

Date: _____

Member name: _____

Remit to:
BEACON, Inc.
1 Congress Street, Suite 201
Hartford, CT 06114-1102

Medical Member for 2008
Please complete below:

Membership Fee

Institution Name: _____

Representative: _____

Address: _____

Phone No. _____

Fax No. _____

Email: _____

Brief Description of Business: _____

New Member Signature: _____

Questions? Please contact Terri Wilson at:

(860) 547-1995
toll free (877) 723-2266
theresa.wilson@beaconalliance.org

Major Hospital:

\$15,000.00

Clinics and Health Care
Service Institutions:

\$5,000.00

Amount enclosed: _____