

MICHIGAN ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS

412 W. Ottawa St.
Lansing, Michigan 48933-1518
www.maemt.org
(517) 372-7391
Fax: (517) 372-1731

Name:
Address:

Preferred mailing address: business
 home
Please complete the information below and return your statement with your payment to the MAEMT office

MEMBERSHIP INVESTMENT STATEMENT

2009 MAEMT Active Member

Membership fees for MAEMT are not tax deductible as charitable contributions for income tax purposes. However, they may be tax deductible as ordinary and necessary business expenses subject to restrictions imposed as a result of MAEMT's lobbying activities. Because MAEMT falls within one of the exemptions, your membership fee deductibility is not affected by these restrictions.
By renewing my membership, I hereby consent to receive any and all communications sent by or on behalf of the Michigan Association of Emergency Medical Technicians via mail, e-mail, phone, and fax.

Dues : \$30.00

(Pay by December 31, and only pay \$25.00!)

Amount Paid: _____

Thank you for your membership renewal!

Please fill in your information below to help us update our records

Business Information:

Company Name:
Company Address

Business Phone:
Business Fax:

Personal Information:

Mailing Address:

Phone:
E-mail:
License Level:

→ APPOINTMENT OF BENEFICIARY – MICHIGAN ASSOCIATION OF EMT'S PLAN ←

All active members receive an Accidental Death & Dismemberment insurance policy.
For your protection, we request that you submit this information annually. Please name your beneficiaries below.

I am a participant in the above benefit plan and hereby revoke any previous appointment and designate the following as revocable beneficiaries of any monies payable upon my death under said plan:

PRIMARY BENEFICIARY NAME (Last)		(First Name)		RELATIONSHIP	
ADDRESS		CITY		STATE	ZIP CODE
CONTINGENT BENEFICIARY NAME (Last)		(First Name)		RELATIONSHIP	
ADDRESS		CITY		STATE	ZIP CODE
SIGNATURE (Required):				DATE:	

Dues Payment Information

Check enclosed, or Visa American Express Discover MasterCard

Credit Card Payment:

Card Number _____ Expiration Date _____
Card Holder's Name (as printed on card) _____ Card Holder's Signature _____