ASSOCIATION OF HEALTH OPPORTUNITY THROUGH PARTNERSHIP IN EDUCATION (HOPE)
Application for Membership

Print – Applicant's Name (First, Middle Initial, Last)	Date of Birth (applicant)	Social Security Number

Applicant's Street Address			
City	**County**	**State**	**Zip Code**

I hereby apply for associate membership to the Association of Health Opportunity through Partnership in Education.

Applicant's Signature: Date:

HOPE-APP (06/11) 140287

(Detach here and leave bottom portion with applicant)

This coverage is being provided through a group policy issued to the HOPE Association. You will be enrolled as an Associate Member before your coverage is issued. There is a $.10 per month ($1.20 per year) membership fee which will be added to and automatically collected with your premium.

HOPE is a non profit organization which is working to promote good health, encourage scientific research and disseminate information concerning the prevention and detection of cancer and other diseases.

For more information you may write to:
HOPE
c/o Statutory Agent
Acme Agent Inc.
41 S. High Street, Suite 2800
Columbus, Ohio 43215

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