



MEMBERSHIP APPLICATION

Name of Applicant: _____

Membership Class: (check one)*

Captive Member

Industry Member

*Note: See attached schedule of initial dues and annual dues.

Contact Information: (fill in all applicable information)

Name: _____ Title: _____

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

If the Applicant is a captive insurance company, please provide the following information:

Domicile: _____ Date of Initial License: _____

Type of captive insurance company: _____

Parent Company (if applicable): _____

Type(s) of Business/Line(s) of Insurance Offered: _____

If the Applicant is not a captive insurance company, please indicate its business and/or the type of services it provides: _____

If admitted as a member of the association, the Applicant will automatically be added to the DCIA's mailing list and email update list. If the Applicant would prefer not to be added to the mailing and email update lists, please check here:

The above-named Applicant hereby applies to become a member, of the class indicated above, of Delaware Captive Insurance Association, a Delaware non-stock corporation (the "Corporation"). The Applicant hereby certifies that it is employed by or in, practices or otherwise does business in, or otherwise is connected with the captive insurance industry in Delaware, and agrees that it will notify the Corporation promptly if and when the foregoing ceases to be true.

Date: _____

Applicant signature (please complete and sign as appropriate):

Organization:

Name:

By: _____

Name: _____

Title: _____

Individual:

Name: _____

Do not complete – for DCIA use only.

Board action:

Application accepted ____ or declined ____.

Date: _____

Initial dues paid: _____

Date: _____

First year annual dues paid: _____

Date: _____



SCHEDULE OF DUES

CAPTIVE MEMBER \$500.00
Any licensed captive insurer.

INDUSTRY MEMBER \$950.00
Any person or company other than a licensed captive insurer.

Payment Information:

Enclosed is my check in the amount of \$ _____
 Please charge the following: Visa Mastercard AMEX Discover
CREDIT CARD NUMBER: _____
EXPIRATION DATE: _____ VAL CODE (last 3 or 4 digits on back): _____
CARD IN THE NAME OF: _____
BILLING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
SIGNATURE: _____

Please Make Checks Payable to: Delaware Captive Insurance Association
62 Rockford Rd.
Wilmington, DE 19806

Employer Identification Number: 20-3619639