



Mississippi Association of Self Insurers
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Membership Application

Organization Name			
Mailing Address and/or Physical Address <i>(if different)</i>			
Type of Organization <i>(Circle or highlight as many as appropriate)</i>	Self-Insured Group Self-Insured Employer <i>Number of employees: _____</i> Actuary Attorney/Law Firm Behavioral Healthcare Management and Employee Assistance Program Benefit Administration Bill Review and Case Management Consultant Medicare Secondary Compliance Services CPA/ CPA Firm Groups and Associations	Healthcare Provider and Special Purpose Physician Insurance Broker/Excess Carrier Investment Advisor/Bank Investigation/Intelligence Firms Pain Management Services Pharmacy, PBM and DME Provider PPO Network / Rehab Provider Network Rehabilitation Service Provider Telehealth Services Third Party Administrators Transportation and Translation Services Wellness Systems and Onsite Service Other: _____	
Contact Person <i>(please print)</i>		Title	
Phone (Office)		Fax	
Phone (Cell)		Email	
Website			

Please provide a brief synopsis of your organization and the services/products provided: