



P.O. Box 46879
 Tampa, FL 33647
 (800) 642-7774 ♦ Fax: (813) 632-9377
 Website: www.wccp.org
 Email: contact@wccp.org

Vendor “Service Partner” Membership Application

Thank you for your interest in the **Association of Workers’ Compensation Claims Professionals**. A WCCP Service Partner Membership is a corporate membership for vendor companies who provide services to the insurance claims industry. Examples include, but are not limited to, law firms, investigation and surveillance companies, transportation providers, accident reconstruction and engineering firms, consulting firms, and others.

Only one Service Partner (corporate) membership is required per company; there is no additional charge for any of your employees, except when and if they attend a WCCP event at a discounted rate.

Your membership will be enrolled in our interactive website at www.wccp.org. If there is more than one representative with your company, a master account will be established along with a sub-account for each additional representative. You can get this process started yourself by joining at wccp.org and then notifying us as to how many sub-accounts are needed, or you can mail your application with your check, or fax it and charge your membership by completing the credit card information below. Please complete all of the requested information.

Membership

(Membership Dues - **\$295.00**/year Per Company)

Company Name: _____

Representative Name: _____
 (or if more than one rep, Master Account holder)

Mailing Address: _____

City: _____ State: _____ Zip+4: _____

Business Phone: _____ Ext: _____ Fax: _____

Marketing Contact Email Address: _____ Website URL: _____

Sub-Account holders: (Use separate sheet if necessary):

1. _____ Email Address: _____

2. _____ Email Address: _____

Note: Payment is due with application, or at time of renewal, so please include check or money order. Make checks payable to “WCCP” and mail to P.O. Box 46879, Tampa, FL 33647. To pay by credit card (Visa, MC, AmEx, Discover) complete the charge card authorization below and fax to (813) 632-9377. There will be a \$35.00 charge for NSF checks.

Charge Card Authorization

Card Name (exactly as it appears on your card): _____

Billing Address for Card: _____
 Street or P.O. Box City State Zip

Credit Card #: _____ Exp Date: _____ Security Code: _____

Signature _____ Date _____ **Email Address: _____

*(**For credit card charges, email address is mandatory. You’ll receive an email receipt immediately upon processing**)*