



2017 MEMBERSHIP FORM
Full Members



This application is for MAM membership from January 1, 2017 to December 31, 2017.
Application due November 25, 2016, with payment in the form of postdated cheque(s)

Name: _____

Mailing address: _____

Street address/PO Box

City

Province

Postal Code

Home phone no.: _____

Email address: _____

- Full Membership (Registered Practicing Midwives*) - \$710.00
Full amount: \$710.00 post-dated Jan 1 2017
Payment Plan: 3 payments - \$260 Jan 1 2017, \$225 Mar 1 2017, \$225 May 1 2017
Discounted rate for Board members (Registered Practicing Midwives*) \$595.00
Full amount: \$710.00 post-dated Jan 1 2017
Payment Plan: 3 payments - \$260 Jan 1 2017, \$225 Mar 1 2017, \$110 May 1 2017

*Proof of current registration with CMM must be presented upon request.

PRIVACY STATEMENT - The Midwives Association of Manitoba will not release your personal information to another person or agency without your signed and informed consent.

RELEASE of INFORMATION CONSENT to HIROC and CAM, and STATEMENT of UNDERSTANDING RE: INSURANCE

- As a member of MAM, I am fully aware that MAM may release my name and contact information to the Canadian Association of Midwives and to HIROC. Both of these agencies are integral components to my MAM membership and neither will distribute my personal information without notifying MAM.
As a member of MAM, I understand that I may be covered by supplementary legal defense insurance through HIROC. If I fail to pay my fees on time, my insurance coverage will lapse without further notification. A \$25 fee will be applied per late or NSF payment.

Signature: _____ Date: _____

For Office Use Only
Date received _____ (postmark or other _____) Initials _____

CHEQUES PAYABLE TO MIDWIVES ASSOCIATION OF MANITOBA INC.
PLEASE COMPLETE AND RETURN THIS FORM TO:

Midwives Association of Manitoba Inc., 3973 Redwood Postal Office, Winnipeg, Manitoba R2W 5H9



2017 MEMBERSHIP FORM
Full Members



Membership Insurance Application Form
Legal Defense Only - 2017
Registered practicing midwives

- 1. Legal name of applicant
2. AKA name (if applicable)
3. E-mail address
4. Mailing address
5. College Registration No.
6. RHA/Employer
7. Work address (site address)

8. Declaration and signature

I declare that to the best of my knowledge, the statements set forth herein are true and further agree that if any significant change is discovered between the date of this application form and the effective date of the policy, which would render this application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurer. Signing this application does not bind the Applicant or Insurer to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued and this form will be attached to and become part of the policy.

Date: Signature of applicant:

CHEQUES PAYABLE TO MIDWIVES ASSOCIATION OF MANITOBA INC.
PLEASE COMPLETE AND RETURN THIS FORM TO:

Midwives Association of Manitoba Inc., 3973 Redwood Postal Office, Winnipeg, Manitoba R2W 5H9