



2018 MEMBERSHIP FORM



This application is for MAM membership from January 1, 2018 to December 31, 2018. Due November 30, 2017 with payment in full or post-dated cheques.

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 2018
Payment Plan:3 payments (\$260 Jan 1 2018, \$225 Mar 1 2018, \$225 May 1 2018)
NEW E-transfer FULL\$710.00 ON JAN 1st, 2018
Discounted rate for Board members (Registered Practicing Midwives*)\$610.00
Full amount: \$710.00 post-dated Jan 1 2018
Payment Plan:3 payments (\$260 Jan 1 2018, \$225 Mar 1 2018, \$125 May 1 2018)
NEW E-Transfer FULL\$ 710.00 ON JAN 1st, 2018

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

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) Initial

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



Membership Insurance Application Form
Legal Defense Only – 2018
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:

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