



Membership Application

YES! I want to join the Alliance and help protect Social Security and Medicare for generations to come. Enclosed is \$10 for a one-year individual/couple membership.

I am enclosing an additional contribution of \$ _____ Total Amount Enclosed: \$ _____

Please print

Name: _____ Date of Birth (optional) _____/_____/_____

Spouse's Name: _____ Date of Birth (optional) _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

E-mail Address: _____

Chapter Name & Number (if applicable): _____

Please make your check or money order payable to: Alliance for Retired Americans.

Please mail this form to the Alliance for Retired Americans at 815 16th Street, NW, Washington, DC 20006.

For credit card payment, fill out below:

Please charge: \$ _____ to my: MasterCard VISA American Express

Card Number: _____ Exp. Date: _____/_____

Cardholder's Name: _____

Authorized Signature: _____

Dues and contributions are not tax deductible. Please allow six weeks for delivery of your membership packet