

Membership Form

NEA • Missouri NEA • Local Association

SCHOOL YEAR* _____ - _____

FOR OFFICE USE ONLY
Transaction Type:
Keyed By:
Date

**All shaded areas to be completed by Local Association representative*

MEMBERSHIP HISTORY

New NEA member this year YES NO

Student NEA member last year YES NO

Social Security Number _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Home E-mail _____

Work E-mail _____

Date of Birth _____ Male Female

ETHNIC GROUP ³

- American Indian/Alaska Native Hispanic
 Asian Multi-racial
 African-American Native Hawaiian/Pacific Islander
 Caucasian (not of Spanish origin)

³ Please read explanation on the back before completing this section.

Designated beneficiary for free insurance ⁴ _____

⁴ Please read explanation on the back.

Relationship of beneficiary to member _____

Member's Signature _____

Date _____

Association Representative's Signature _____

School District _____

(required only at initial enrollment)

E-Z PAY FORM

I (we) hereby authorize Missouri NEA to initiate debit entries to my (our) account indicated below and the bank named below, hereinafter called BANK, to debit the same to such account. I (we) will not hold our BANK liable for any erroneous debits made by Missouri NEA.

Bank Name _____

Bank Address _____

City _____

State _____

Zip _____

Bank Transit Number | : _____ : |

Account Number _____

This authorization is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notification to BANK prior to charging account. After account has been charged, a customer has the right to have the amount of the erroneous debit immediately credited to his account by BANK up to fifteen (15) days following issuance of statement of account or forty-five (45) days after the charge, whichever occurs first.

Name *(as it appears on the account)* _____

Social Security Number _____

Signed _____

Date _____

Total Obligation \$ _____ Monthly Payment Amount \$ _____ Starting Date* ____ / 10 / ____ Number of Monthly Payments* _____

**A member can have up to 10 deductions per year (October–July only). The monthly payment amount will be charged to your checking account on or near the 10th day of each month. You will be mailed a payment schedule showing the amounts to be deducted monthly.*

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS A VOIDED PERSONAL CHECK IS ATTACHED.