



NEW YORK STATE SOCIETY OF MEDICAL MASSAGE THERAPISTS



Personal Information

First Name _____

Last Name _____

Address _____

City _____

State _____ Zip _____

Email _____

Home Phone _____

Cell Phone _____

Birth Date (mm/dd/yyyy) _____

Additional Insured (add \$10.00 to payment)

Business / Owner Name _____

Address _____

City _____

State _____ Zip _____

Email _____

Phone _____

Relationship to You _____

Please return Completed forms to:

Massage Magazine Insurance Plus
5150 Palm Valley Rd.
Suite 103
Ponte Vedra Beach, FL 32082

Phone: 800.222.1110 Fax: 904.285.9944

Payment Information (for NYSSMMT members only)

\$139.00 Professional \$69.00 Student

First Name _____

Last Name _____

Check # _____

Credit Card Type

VISA MasterCard American Express DISCOVER

Card Number _____

Expiration Date (Month/Year) _____

Security Code _____

Billing Address _____

Billing City _____

State _____ Zip _____

Billing Phone _____

I represent that the all statements in this application are true and no material facts have been suppressed or mis-stated. As of this date, I have no knowledge of any allegation, claim or lawsuit or any act, error or omission, which might reasonably be expected to result in a claim or lawsuit.

Name

Signature

Massage Magazine Insurance Plus

Massage Magazine Insurance Plus includes Professional (malpractice) Liability, General ("trip & fall") Liability, Product Liability: \$2 million of protection per year / \$3 million aggregate \$2 million product aggregate, \$100,000 Rental Damage, \$15,000 Identity Protection and \$1,000 Lost or Stolen Table and Equipment Coverage.