

MEMBERSHIP RENEWAL

2018-2019

We wish to renew our membership of the Chronic Illness Alliance Inc.

We have included the following with our renewal application:

- Membership fee* *[See over for details*]*
- Signed agreement to accept the aims and objectives of the Chronic Illness Alliance Inc
- Additional delegates
- We wish to become organisational members of the Peer Support Network

Please return COMPLETED renewal* to L1, 650 Mount Alexander Road MOONEE PONDS VIC 3039
or email admin@chronicillness.org.au

Please use BLOCK letters

Organisation _____

Representative/Individual Title _____ Name _____

Address _____

PCode _____

Telephone: _____ Mobile: _____

Fax: _____ Email: _____

Membership Categories

- VOTING** Organisations who accept the aims and objectives of the Chronic Illness Alliance
- ASSOCIATE*** Organisations or Individuals with an interest in chronic illness issues

On behalf of [Organisation] _____

I agree to abide by the aims and objectives of the Chronic Illness Alliance Inc. as set out in the Constitution *[Visit www.chronicillness.org.au to view]*

I acknowledge that acceptance as a member of the Chronic Illness Alliance is subject to approval by the Committee of Management.

_____ Date _____

Payment is enclosed/paid by direct deposit paid on _____ *[See over]*

* We require your COMPLETED form to comply with our legislative obligations – thank you for your cooperation.

*Associate Members do not have voting rights

Pay by cheque

Forward renewal and cheque payable to
Chronic Illness Alliance
 Level 1, 650 Mount Alexander Road,
 MOONEE PONDS VIC 3039
 along with the completed membership form

Pay by EFT

BSB 633 000 Account 1300 20233
 Chronic Illness Alliance, and e-mail the
 completed membership form to
admin@chronicillness.org.au

ANNUAL MEMBERSHIP FEES

Membership fees all include GST	Organisations	
	Annual income	Fee
	Individuals	\$23.00
	Under \$10,000	\$23.00
	\$10,001-\$150,000	\$38.00
	\$150,001-\$350,000	\$98.00
	\$350,001-\$1 million	\$195.00
	\$1 million plus	\$425.00

ADDITIONAL DELEGATES FOR _____

Name:

ADDRESS:

State Postcode Phone: Fax:

Email:

Please put me on the mailing list for Peer Support Network CDSM SIG*

Name:

ADDRESS:

State Postcode Phone: Fax:

Email:

Please put me on the mailing list for Peer Support Network CDSM SIG***PRIVACY POLICY**

Our Privacy Policy dictates how we collect, use and disclose personal information. Please visit www.chronicillness.org.au for a copy of this policy.

*CDSM SIG (Chronic Disease Self Management Special Interest Group)