

# 2010 CONFERENCE & GOLF TOURNAMENT REGISTRATION

The Texas Association of Health Plans Texas Managed Care Conference and Trade Show

**ONE FORM PER PERSON PLEASE.** Please copy form for additional attendees. Payment must accompany form.  
For more information, please visit us at [www.taahp.org](http://www.taahp.org) or contact Patti Doner at 512.476.2091 or [pdoner@taahp.org](mailto:pdoner@taahp.org)

## CONFERENCE REGISTRATION

- Member Registration** – \$550 (\$500 if registered and paid before September 15, 2010)  
(includes all conference events except the golf tournament)..... **Amount \$** \_\_\_\_\_
- Non Member Registration** – \$850 (\$800 if registered and paid before September 15, 2010)  
(includes all conference events except the golf tournament)..... **Amount \$** \_\_\_\_\_
- Welcome Reception Pass for Spouse/Guest** – \$75  
(Tuesday, November 9, 2010/5:30 p.m. to 7:30 p.m.) ..... **Amount \$** \_\_\_\_\_
- Dinner Banquet and Casino Night Pass for Spouse/Guest** – \$75  
(Wednesday, November 10, 2010/7:00 p.m. to 10:00 p.m.) ..... **Amount \$** \_\_\_\_\_
- Single Day Registration** – \$200 members/\$350 non-members  
(Please specify day: Tuesday/Wednesday) ..... **Amount \$** \_\_\_\_\_

## GOLF TOURNAMENT REGISTRATION

- Register** \_\_\_\_\_ **players** for the golf tournament – \$150 each ..... **Amount \$** \_\_\_\_\_
  - Rent golf equipment for** \_\_\_\_\_ **right handers** and \_\_\_\_\_ **left handers** – \$40 each ..... **Amount \$** \_\_\_\_\_
- Total Amount Due \$** \_\_\_\_\_

## ATTENDEE/SPOUSE/GUEST INFORMATION *(to be used for name tags)*

First \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Title \_\_\_\_\_ Company/Org. \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
Spouse/Guest Name \_\_\_\_\_

## PAYMENT METHOD

- Check** (Amount enclosed \$ \_\_\_\_\_) Please make checks payable to Texas Association of Health Plans
  - Credit Card** (Circle: AMEX, MC, VISA) CC# \_\_\_\_\_ Expiration date \_\_\_\_\_
- Billing Address** *(if different from above)* \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name on credit card \_\_\_\_\_ Authorized Signature *(required)* \_\_\_\_\_

**MAIL** *(paying with check)* **OR FAX** *(paying with credit card)* **THIS FORM WITH PAYMENT TO :**  
Texas Association of Health Plans, 1001 Congress Ave., Suite 300, Austin, TX 78701 OR Fax to 512-476-2870

FOR MORE INFORMATION, CONTACT US AT:



**Texas Association of Health Plans**  
Phone: 512-476-2091 • Fax: 512-476-2870  
Web: [www.taahp.org](http://www.taahp.org)