



American Health Lawyers Association
Program Registration Form
Payors, Plans and Managed Care Law Institute
November 8-9, 2010
Chicago Marriott Magnificent Mile • Chicago, IL

To register: Remit payment and completed registration form
by mail to the American Health Lawyers Association, PO Box 79340, Baltimore, MD 21279-0340
by fax with credit card information to (202) 775-2482 by phone to AHLA Member Service Center at (202) 833-1100, prompt 2

Cancellations/Substitutions: Cancellations must be received in writing no later than November 1, 2010. Registration fees, less a \$125 administrative fee will be refunded following the program. If you wish to send a substitute, please call AHLA's Member Service Center at (202) 833-1100 prompt 5. Please note that registration fees are based on the membership status of the individual who actually attends the program.

Hotel: Hotel accommodations are not included in the registration fee. Call the Marriott at (800) 266-9432. Indicate that you are attending the AHLA program to be eligible for the special group rate of \$199 single or double occupancy. The room block expires October 18, 2010. Rooms at the group rate are limited and may sell out prior to the cut-off date.

Name: _____

First Name for Badge (if different than above): _____

Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ This is new address information;

Telephone: (_____) _____ Fax: (_____) _____ please update my file.

REGISTRATION FEES Please mark appropriate boxes below (registration fees increase \$125 after October 18, 2010*):

My colleague attended the 2009 Payors, Plans & Managed Care Law Institute and I am eligible for the member rate for the 2010 program

AHLA Member Rate: \$730

Name of AHLA Member who attended 2009 PPMC Law Institute: _____

Printed Course Materials \$45

LUNCHEON – Payors, Plans, and Managed Practice Group – November 8, 2010

\$35 for PPMC Practice Group Members

\$45 for PPMC Practice Group Non-Members

ADULT GUEST FEE: \$30

Guest Name: _____

Total Enclosed: \$ _____

PAYMENT INFORMATION (Registrations cannot be processed unless accompanied by payment.)

Check enclosed (U.S. funds; make payable to American Health Lawyers Association)

Bill my credit card: VISA MasterCard American Express Discover Diners Club

Card Number: _____ Exp. Date: _____

Name of Cardholder: _____

Signature of Cardholder: _____

ZIP Code of Cardholder's Billing Address: _____ - _____

Please note: AHLA will charge your credit card for the correct amount if your total is incorrect.