



Blinded Veterans Association

Membership Application

125 N. West st, 3rd Floor

Alexandria, VA 22314

(202) 371-8880 or (800) 669-7079 www.bva.org

Dues have been reduced to **\$25.00** beginning August 17, 2018

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone No: _____ Cell No: _____ DOB: _____
Social Security #: _____ Email: _____

Membership Election (please select one of the following membership types.)

Life Member (Service Connected for Blindness.)

\$25

Associate Life Member (Not Service Connected for Blindness.)

\$25

BVA Bulletin (Please select one of the following formats.)

I will download from bva.org (please send an email notification.)

Email PDF version Email Word version Mail Print Version Mail CD

Billing Information

Payment Amount \$

Check or money order Please call me Credit/Debit Card

Card Holder Name as it appears on Card:

Bill Address:

City: _____ State: _____ Zip: _____

Card Number: _____ Expires: _____ Security Code: _____

Card Holder Signature: _____

(NOTE) Please enclose a copy of your VIST Coordinator's or physician's letter of legal blindness.

Referred by: _____

FL2019