

**Special Offer for Hood County Residents**

**It's Your Life & Your Right**

**5 Years for the Price of 1 Year**



**Ask for CareFlite by Name**



**Members Services Office**  
 3110 S. Great SW Parkway  
 Grand Prairie, Texas 75052  
 (877) 339-2273 (M-F 8a-5p)  
 (A Texas 501C3 non-profit entity)



**Caring-Heart Membership**  
 Hood County Residents Application  
 Plan Year 1/1 - 12/31

**1**



**5 Years \$49**  
 Check here for 5 Years for the price of 1 year; normally \$49/yr

Note: If you are already a Member of CareFlite, please give this application to a friend or extend your Membership for \$10 per Year per Household.

**2** Fill out & mail this application with your payment to: CareFlite, 3110 S. Great SW Parkway, Grand Prairie, TX 75052.

Applications postmarked on or before 1/15/11 will be effective on 1/1/11. All others will be effective on the date of the postmark or fax to (972) 602-7182. All memberships in this group will renew each year on January 1st.

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Address or PO Box: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: Hood

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_@\_\_\_\_\_.

Date of Birth: \_\_\_\_\_  Male  Female Employer Name: \_\_\_\_\_

Primary Insurance:  No  Yes, if yes, Insurance name \_\_\_\_\_

Supplement Insurance:  No  Yes, if yes, Insurance name \_\_\_\_\_

**LIST Other Family Members of Household (For additional household family members, please copy this page and attach to this application).**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

Primary Insurance:  No  Yes, if yes, Insurance name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

Primary Insurance:  No  Yes, if yes, Insurance name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

Primary Insurance:  No  Yes, if yes, Insurance name: \_\_\_\_\_

**Membership Benefit Includes San Antonio AirLife And Corpus Christi HaloFlight if you are flown by those programs in their service areas.**

**3** DO NOT SEND CASH – Please make \$49 check payable to CareFlite or apply by credit card below. If applying by credit card, you may fax your application to (972) 602-7182 anytime 24/7.

Card Type \_\_\_\_\_ Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Billing Zip Code \_\_\_\_\_ Date \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature for Processing, Acceptance of Terms & Credit Card (if Used): \_\_\_\_\_

Fill out only if using Credit Card



**4** All Applicants Sign here

By Paying the CareFlite Membership fee I agree (on behalf of my family) to abide by the terms and wish to hereby apply for Air Membership in the CareFlite Caring Heart Membership Program for myself and members of my household listed on the Application, as set forth in this Agreement. I have reviewed the Caring-Heart Air Membership Agreement and agree to abide by the terms thereof. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to CareFlite for any emergency services and supplies furnished to me by CareFlite. I authorize any holder of any of any of my medical information to release that information to the CMS, its agents and carriers, or CareFlite, in order to determine benefits payable on my behalf, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign. I understand that under the State rule 157.11 k, if I or a household member is a Medicaid recipient, then I am not allowed to have them on my Application, therefore, I am stating that I have not listed on my application anyone that is a Medicaid recipient. If a family member becomes a recipient of Medicaid, I will notify CareFlite in writing of this life change immediately. I warrant that all the information in the Application is true and correct. CareFlite reserves the right to request documentation demonstrating the accuracy of such information. I acknowledge that membership in CareFlite Caring-Heart Membership Program is simply a membership in a program sponsored by CareFlite, and thus, is not membership in CareFlite's non-profit corporate entity as the term membership is contemplated under the Texas Non-Profit Corporation Act.

<b>For CareFlite Office Use Only:</b>	<b>Welcome Card Sent on:</b>
Date Received: _____ Form of Payment: _____ Amount Paid: _____ / / _____	
Membership # Assigned: _____ Date Sent to Fulfillment: _____ Emp Initial: _____	

**Protect your Family & Finances... Just \$10 / Yr / House  
Includes Helicopter/Fixed Wing/Ground EMS  
Across DFW Metroplex and North Texas**



**It's Your Life. It's Your Right. Ask for CareFlite by Name**



**Caring – Heart Membership Program**

**PERSONS COVERED:** This Agreement covers the household family members listed on this application, so long as they remain full-time residents (including college students) of my household. New residence family members may be added, others deleted or the household location changed by written notice to CareFlite at the address shown above. Added members will be effective as of the postmark date on the envelope. Medicaid recipients may not enroll by law.

**EFFECTIVE DATE:** This application will be effective on the date of the postmark on the envelope in which the application and payment are submitted to CareFlite except for those submitted on or prior to 11/15/10 which shall be effective on 11/1/10.

**BENEFITS:** Payment of the membership fee and compliance with the terms of this program/agreement entitles the members shown on the reserve side to the following benefits:

1. Emergency helicopter air ambulance services originating within 150 miles of DFW Airport for medically necessary advanced or basic life support emergency transport services from CareFlite as a result of an emergency medical condition shall pay nothing out of pocket, unless otherwise specified herein.
2. Emergency fixed wing air ambulance services for patients needing a higher level of care originating within 500 miles of DFW Airport and within the United States shall pay nothing out of pocket. For non-medically necessary fixed wing transports, CareFlite will make its best efforts to obtain an insurance pre-authorization. For fixed wing air ambulance service that are not medically necessary and/or operated for patient or family convenience, CareFlite will give members a 50% discount from its standard rates.
3. CareFlite's ground ambulance and 911/EMS service will be available with its service areas. These benefits will follow the rules of this Air Ambulance membership program. Certain other air medical programs have reciprocal benefits. See [www.careflite.org](http://www.careflite.org) for complete details.

**PAYMENT FOR SERVICES:** I understand that I am responsible for payment for any services provided to me by CareFlite, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those CareFlite services specified in this Agreement. This benefit is subject to certain limitations specified in this agreement. As a condition of receiving this benefit, I hereby assign (hand over) to CareFlite all rights and benefits that I or the other family members of my residence have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for ambulance services. Such payment sources are collectively referred to in this agreement as "insurance". I authorize the payment of all insurance benefits or payments to CareFlite. I understand that CareFlite will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance up to the amount of CareFlite's charges for its services. When requested by CareFlite, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receives any insurance or other third party payments for services provided by CareFlite, I will promptly forward those payments to CareFlite at the address shown at the top of this form.

**LIMITATIONS and CONDITIONS:** Membership benefits extend to CareFlite's critical care, advanced or basic life support helicopter and fixed wing air ambulance services staffed with nurses, paramedics and pilots, Specialty Care Transport (a ground transport staffed similarly to CareFlite's air ambulance services) as well as ground ambulances staffed with quality trained paramedics and EMTs. Member benefits are not applicable to services rendered by any other provider. As a condition of receiving the benefits of membership with respect to any air or ground ambulance transport, members with insurance agree to and must comply with all coverage conditions of their applicable insurance program for such transport. Some insurance programs require the insured person to obtain prior authorization of payment for non-emergency, yet medically necessary air ambulance services. (This requirement typically applies to fixed wing air ambulance and inter-facility ground ambulance only but not to helicopter or 911/EMS emergency services.) Non-insured household family members will automatically receive a 50% membership discount on CareFlite's standard charges for the services rendered. Some plans require certain documentation from the insured within a specified time limit or the plan(s) deny or reduce coverage for ambulance services. In the event the member with insurance forfeits coverage by failing to comply with these types of requirements for a transport that would otherwise be covered by insurance, the member will then forfeit membership benefit for failing to so comply and their membership can be revoked at CareFlite's discretion. Membership is available for sale only in those counties or jurisdictions shown on CareFlite's website [www.careflite.org](http://www.careflite.org). Ground ambulance benefits are available to all members but only in CareFlite's ground ambulance service areas. The member must hold a membership that is in good standing at the time of service and the transport must originate in CareFlite's deemed service area with CareFlite as the transporting agency. CareFlite reserves the right to deny or revoke any membership for reasonable cause. If membership is revoked then all balances are due in full. CareFlite may terminate the membership program at any time upon notice to the members. If CareFlite terminates the program, members will have any unused, prorated portion of their membership fee returned. To protect member fees, CareFlite maintains a bond with an A rated insurance company.

**Note: If you are already a Member of CareFlite, you can extend your current membership for only \$10 / Year / House by calling (877) 339-2273 or give this application to a friend.**

CareFlite is a 501(c)3 Not For Profit Air and Ground Ambulance Service Sponsored by:



[WWW.CAREFLITE.ORG](http://WWW.CAREFLITE.ORG) ♥ MEMBERSHIP (877) DFW CARE

CareFlite 3110 S. Great Southwest Pkwy., Grand Prairie, TX 75052