



Membership Application - Healy Senior Center

By applying for membership, I agree to AMCN's and/or Fly-U-Home's terms and conditions on the reverse side. Initials _____ Today's Date ____/____/____

STEP 1 Member Contact Information (please print)

First Name	Last Name	Date of Birth / /	Home Phone	Cell Phone
Mailing Address	City	State	Zip	County
Do you live within the city limits? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Physical Street Address (If different from above)	City	State	Zip	E-Mail Address In order to sign up with recurring payment options, you must provide a valid email address.

STEP 2 List Additional Members in Household

First Name	Last Name	Date of Birth / /	First Name	Last Name	Date of Birth / /
First Name	Last Name	Date of Birth / /	First Name	Last Name	Date of Birth / /
First Name	Last Name	Date of Birth / /	First Name	Last Name	Date of Birth / /

STEP 3 Choose an AMCN Household Membership Option (select one)

1-Year Membership \$55

Multi-year memberships are not available in Indiana or California

Fly-U-Home Add On Membership Option

1-Year Membership Fly-U-Home Add-On[‡] **\$15 Savings!** \$134

[‡]Electronic Funds Transfer (EFT) not available with Fly-U-Home Memberships

Knox Keene Statement

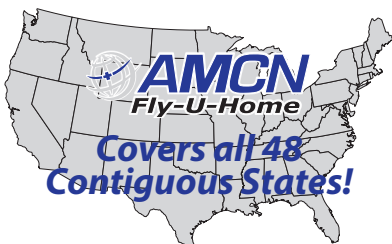
BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by Reach/AirMed International LLC may duplicate the benefits provided by your HMO or other health insurance. If you have a questions regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

WARNING: Reach/AirMed International LLC is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur when Reach/AirMed International LLC is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being called on another flight.

COMPLAINTS: For complaints regarding Reach/AirMed International LLC, first attempt to call the plan at 1 800 793 0010. If Reach/AirMed International LLC fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1 888 466 2219. The Department's website is <http://www.healthhelp.ca.gov>. You may obtain complaint forms and instructions online.

OPERATING UNDER CONDITIONAL EXEMPTION: Reach/AirMed International LLC is operating pursuant to an exemption from the Knox Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq).

Initial or sign here _____



STEP 4 Choose a Payment Option (select one)

Check or money order made payable to:
AirMedCare Network, PO Box 948, West Plains, MO 65775 # _____
Check or Money Order Number

Bank Information (required for monthly membership option and automatic transfers from checking account)

Name on bank account (please attach a voided check) _____

Routing number _____ Account number _____

One Time transfer from checking account or credit card.
 VISA MasterCard Discover American Express

Credit Card Number _____ Expires _____

3 digit code on back of card _____ **X** Signature _____

Statement of Authorization I authorize AirMedCare Network to initiate the EFT withdrawal as indicated above. If I have elected to pay by credit card, I agree to abide by all terms and conditions of my credit card agreement. If I have elected to pay via EFT, I authorize my financial institution to transfer the amount indicated on the attached voiced check to AirMedCare Network. Adjusting entries to correct errors are also authorized. It is agreed that these debits and adjustments will be made electronically and under the rules of the National Automated Clearing House Association (NACHA). This authorization is to remain in full force and effect until written notification is given to the AirMedCare network of its termination.

X _____ / ____ / ____
(Signature required for Credit Card/EFT Authorization) month day year

FOR OFFICE USE ONLY

GET CODE	TRACK CODE	PLAN CODE
	12952	8155

**Questions? Call Membership Sales Manager or visit www.AirMedCareNetwork.com
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