



↓ Mark One
 New Member
 RENEWAL

SEE IMPORTANT NOTICES ON PAGE 2 PRIOR TO PURCHASE

Air Membership Application (2007-2008)

MAIL THIS FORM AND PAYMENT TO: PHI 801-D AIRPORT WAY, MODESTO, CA 95354

Membership covers all listed members that reside in your household



Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Physical Address _____ **City** _____ **State** _____ **Zip** _____

County of Residence _____ **Phone** (_____) _____

EMAIL(optional) _____



HEAD OF HOUSEHOLD

First _____ MI _____ Last _____ SS# _____ Date of Birth _____

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

OTHER MEMBERS OF HOUSEHOLD

First _____ MI _____ Last _____ SS# _____ Date of Birth _____

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

[Relationship to Head of Household _____]

OTHER MEMBERS OF HOUSEHOLD

First _____ MI _____ Last _____ SS# _____ Date of Birth _____

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

[Relationship to Head of Household _____]

OTHER MEMBERS OF HOUSEHOLD

First _____ MI _____ Last _____ SS# _____ Date of Birth _____

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

[Relationship to Head of Household _____]

OTHER MEMBERS OF HOUSEHOLD

First _____ MI _____ Last _____ SS# _____ Date of Birth _____

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

[Relationship to Head of Household _____]

PLEASE ATTACH OTHER PAGES TO INCLUDE ADDITIONAL MEMBERS OF YOUR HOUSEHOLD

MEMBERSHIP ANNUAL FEES

Plan Types	Individual Annual Fees	Household Annual Fees	Group Annual Fees
With Two Forms of Health Insurance	\$40.00	\$50.00	\$30.00
With One Form of Health Insurance	\$50.00	\$60.00	\$40.00
With No Health Insurance	\$80.00	\$100.00	\$60.00

In the event some household members fall into different membership fee categories than others (e.g., the head of the household has primary and secondary insurance and one or more other household members are primary insurance only), contact the PHI Air Medical/Mercy Air Membership Office to determine the amount of the fee payable by the household using a formula that blends the rates payable by the different categories of individuals in a way that takes into account the number of members that fall into each category.

METHOD OF PAYMENT: VISA ___ MASTERCARD ___ DISCOVER ___ CVN(3 digit code) ___
CREDIT CARD NUMBER: _____ EXPIRATION DATE _____
CHECK ___ MONEY ORDER _____ **Amount Paid \$** _____

****Group Rates:** To qualify for group rates, you and your household must be part of established group with Mercy Air, and the group name must be written in the space provided below.

GROUP NAME: _____

As of May 8, 2005, Group Coordinators are responsible for sending one check on behalf of all group members.

There is a fifteen (15) person minimum for new and existing groups.

All members in said group must have the same expiration date.

NOTICES REQUIRED BY THE DEPARTMENT OF MANAGED HEALTH CARE:



(A) **BEFORE YOU PURCHASE:** If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

(B) **WARNING:** This Ambulance Plan 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 the 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 this Ambulance Plan is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being on another call.


 **SIGN OR INITIAL HERE**

(C) **COMPLAINTS:** For complaints regarding this Ambulance Plan, or if you have questions regarding the Plan, first attempt to call Mercy Air at 800-500-1260. If the Mercy Air fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1-800-400-0815. The Department's website is <http://www.dmhc.ca.gov>. You may obtain complaint forms and instructions online.


(D) **OPERATING UNDER CONDITIONAL EXEMPTION:** This Ambulance Plan 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.).

 **All membership applicants 19 years or older must sign below** 

I hereby apply for membership in the Mercy Air Membership program. I have reviewed the Mercy Air Membership Plan Coverage 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 Mercy Air for any ambulance services and supplies furnished to me by Mercy Air. I authorize any holder of medical information about me or minors within my household to release that information to the Centers for Medicare and Medicaid Services, other providers, their agents and carriers, or Mercy Air, 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 other members of my household, if they are minors or otherwise unable to sign. In the event of any change in the insurance coverage or status specified on this application, I agree to notify Mercy Air within ten (10) days and, if the change results in the affected member(s) owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from Mercy Air specifying the additional amount due. Failure to notify Mercy Air of any such change or to pay any additional amount due within thirty days of the invoice date shall result in the automatic termination of this Agreement without any notice to the affected member. By signing this application for Membership, I agree to all conditions of the "Mercy Air Ambulance Plan Coverage Agreement" as stated in said contract.

 X _____ Date
SIGNATURE OF HEAD OF HOUSEHOLD

 X _____ Date
SIGNATURE OF OTHER ADULT MEMBER or SIGNATURE OF PRIMARY MEMBER WHO IS AUTHORIZED TO SIGN FOR MINOR HOUSEHOLD MEMBERS.

 X _____ Date
SIGNATURE OF OTHER ADULT MEMBER

 X _____ Date
SIGNATURE OF OTHER ADULT MEMBER