# Application for Membership

## Membership Program
A Service of Enloe Medical Center

**$40** INDIVIDUAL *One Year Membership*

**$50** FAMILY *One Year Membership*

**$30** GROUP ($30 per individual or family) *One Year Membership*

***Please Check One:** ❑ Individual ❑ Family ❑ Group _____ (Group Affiliation)

❑ New Member ❑ Renewal or Current Member

**Please Print** (Head of Household)

Last Name _____ Telephone ( )

Street Address _____ Apt #

City _____ State Zip

Email Address

Mailing Address (if different from above)

City _____ State Zip

**Household members:**

***List only dependents who are claimed on your tax return.**
***Please list any last name that is different than the Head of Household name above.**

| | Last Name (If different from Head of Household) | First Name | Middle Initial | Relationship to Head of Household | Date of Birth |
|---|---|---|---|---|---|
| Head of Household | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |



***Please complete both sides and return this sheet with your payment.***

# Enloe FlightCare Membership Program

**Statement of understanding**
For complaints regarding Enloe FlightCare Membership Program, call us at (530) 332-6774. If we fail to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at (800) 400-0815. The Department's website is www.dmhc.ca.gov. You may obtain complaint forms and instructions online.
Enloe FlightCare 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.).

**Before you purchase**
If you are currently in a health maintenance organization (HMO) or other health insurance, the benefits provided by an air 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 air ambulance services, you should contact that company directly.

***WARNING:*** The Enloe FlightCare Membership Program is not an insurance program. It will not compensate or reimburse another ambulance company for providing 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 Enloe FlightCare is unable to perform within a medically appropriate timeframe due to severe weather, a maintenance issue or being committed to another call.

**Initial** _____

**Statement of understanding**

1. I understand Enloe FlightCare Membership Program benefits are for myself, my spouse and dependents (those claimed on my income tax forms) listed on this form for the type of membership indicated.
2. I understand that Enloe FlightCare benefits only apply when an Enloe FlightCare member is transported by Enloe FlightCare or a reciprocating program.
3. I transfer, directly to Enloe FlightCare, my rights to air medical insurance payments due me. Such payments shall not exceed FlightCare's regular charges. Enloe FlightCare will respond based on medical necessity only. Medical necessity must be determined by a health care professional, a pre-hospital health care provider, or a third party recognized by FlightCare (excepting cases of extreme remoteness).
4. New member benefits take effect three days after receipt of a completed application with payment.
5. Enloe FlightCare membership fees are non-refundable and the membership is non-transferable.
6. I understand the FlightCare program or the FlightCare Membership Program may be canceled at any time for any reason.
7. I understand my membership is not an investment, and does not provide any form of financial security or any form of insurance to me, my spouse, or dependents. I understand that the primary purpose for my membership is to support FlightCare and local community emergency medical services. I specifically waive any and all rights, claims or causes of action against Enloe Medical Center, its employees and agents with respect to my FlightCare membership and the FlightCare Membership Program.

***I understand that Enloe FlightCare will be used only for medically appropriate transports and that Enloe Medical Center will bill a member's insurance plan, if any, but will not bill the member-patient for any remaining balance.***

**Applicant Signature** _____ **Date** _____

Please mail completed application to:

**Enloe Medical Center FlightCare Membership**
1531 Esplanade
Chico, CA 95926

A check, money order or credit card information must accompany this application. Please make check payable to Enloe Medical Center.

I have enclosed my payment by:

❑ Check ❑ Money Order ❑ Cash ❑ Mastercard ❑ VISA ❑ DISCOVER

Credit Card # _____ / _____ / _____ / _____ Expiration Date _____ / _____ CCV Code

***Your cancelled check, credit card statement or money order receipt is proof of membership.***
***Please complete both sides and return with your payment.***