

Membership Terms and Conditions

AirMedCare Network is an alliance of affiliated air ambulance providers* (each a "Company"). An AirMedCare Network membership automatically enrolls you as a member in each Company's membership program. Membership ensures the patient will have no out-of-pocket flight expenses if flown by a Company by providing prepaid protection against a Company's air ambulance costs that are not covered by a member's insurance or other benefits or third party responsibility, subject to the following terms and conditions:

1. Patient transport will be to the closest appropriate medical facility for medical conditions that are deemed by AMCN Provider attending medical professionals to be life- or limb-threatening, or that could lead to permanent disability, and which require emergency air ambulance transport. A patient's medical condition, not membership status, will dictate whether or not air transportation is appropriate and required. Under all circumstances, an AMCN Provider retains the sole right and responsibility to determine whether or not a patient is flown.
2. AMCN Provider air ambulance services may not be available when requested due to factors beyond its control, such as use of the appropriate aircraft by another patient or other circumstances governed by operational requirements or restrictions including, but not limited to, equipment manufacturer limitations, governmental regulations, maintenance requirements, patient condition, age or size, or weather conditions. FAA restrictions prohibit most AMCN Provider aircraft from flying in inclement weather conditions. The primary determinant of whether to accept a flight is always the safety of the patient and medical flight crews. Emergent ground ambulance transport of a member by an AMCN Provider will be covered under the same terms and conditions.
3. Members who have insurance or other benefits, or third party responsibility claims, that cover the cost of ambulance services are financially liable for the cost of AMCN Provider services up to the limit of any such available coverage. In return for payment of the membership fee, the AMCN Provider will consider its air ambulance costs that are not covered by any insurance, benefits or third party responsibility available to the member to have been fully prepaid. The AMCN Provider reserves the right to bill directly any appropriate insurance, benefits provider or third party for services rendered, and members authorize their insurers, benefits providers and responsible third parties to pay any covered amounts directly to the AMCN Provider. Members agree to remit to the AMCN Provider any payment received from insurance or benefit providers or any third party for air medical services provided by the AMCN Provider, not to exceed regular charges. Neither the Company nor AirMedCare Network is an insurance company. Membership is not an insurance policy and cannot be considered as a secondary insurance coverage or a supplement to any insurance coverage. Neither the Company nor AirMedCare Network will be responsible for payment for services provided by another ambulance service.
4. Membership starts 15 days after the Company receives a complete application with full payment; however, the waiting period will be waived for unforeseen events occurring during such time. Members must be natural persons. Memberships are non-refundable and non-transferable.
5. Some state laws prohibit Medicaid beneficiaries from being offered membership or being accepted into membership programs. By applying, members certify to the Company that they are not Medicaid beneficiaries.
6. These terms and conditions supersede all previous terms and conditions between a member and the Company or AirMedCare Network, including any other writings, or verbal representations, relating to the terms and conditions of membership.

*Air Evac EMS, Inc. / EagleMed LLC / Med-Trans Corporation / REACH Air Medical Services, LLC — These terms and conditions apply to all AirMedCare Network participating provider membership programs, regardless of which participating provider transports you.

Membership Application

By applying for membership, I agree to AMCN's terms and conditions.

STEP 1 Member Contact Information (please print)

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

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 / /

STEP 3 Choose a Membership Option (select one)

<input type="checkbox"/> Platinum (25 Year) Membership*	Household Cost	\$1125
<input type="checkbox"/> 10-Year Membership*	Household Cost	Best \$550
<input type="checkbox"/> 5-Year Membership*	Household Cost	Better \$275
<input type="checkbox"/> 3-Year Membership*	Household Cost	Good \$165
<input type="checkbox"/> 1-Year Membership	Household Cost	\$55

*Multi-year memberships are not available in Indiana or California

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

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

Bank Information

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

Name on bank account (please attach a voided check)	Credit Card Number
Routing number	Expires
Account number	3 digit code on back of card
	X Signature

Total Payment Amount \$ _____

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 voided 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
9218	12952	6702

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