Enloe FlightCare Membership Program

Application for Membership

Membership Type (One Year Membership) *

- ◯ $40 - Individual
- ◯ $50 - Family
- ◯ $30 - Group ($30 per individual or family)
- ◯ $130 - Combined FlightCare & Ground Ambulance
- ◯ Click here for ONLY Butte County EMS Ground Ambulance
- ◯ Click here for ONLY Colusa Ground Ambulance

Membership Status: *

- ◯ New Member
- ◯ Renewal or Current Member

Member Number ***(if current member)***

Name (Head of Household) *

First Last

Phone Number *

– ### –

Date of Birth *

MM / DD / YYYY

Email

Address *

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

United States

Country

Mailing Address ***(if different from above)***

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

United States

Country

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 named above.

Dependent		Relationship	Date of Birth
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY
First	Last		MM / DD / YYYY

First Last MM DD YYYY

Please read the statement below carefully,
then type your name acknowledging agreement.

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 *