PHI CARES
National Air Membership Program
A service of PHI Air Medical

BEYOND THE CALL

CALIFORNIA AIR AMBULANCE MEMBERSHIP APPLICATION

GROUP NAME: THE TEXAS MILE

SEE IMPORTANT NOTICES ON PAGE 2 PRIOR TO PURCHASE

Mailing Address ______________________ City ________________ State _____ Zip ________

Physical Address ______________________ City ________________ State _____ Zip ________

Home Phone #: (_____)________________ Alternative Phone #: (_____) ________________

Email (optional) ______________________

Head of Household
First Name: ________________ MI_____ Last Name: ________________
Date of Birth ____________ Does this member have medical insurance? Yes☐ No ☐

List all additional members of household. Please attach a separate sheet of paper if necessary.

First Name: ________________ MI_____ Last Name: ________________
Date of Birth ____________ Does this member have medical insurance? Yes☐ No ☐

First Name: ________________ MI_____ Last Name: ________________
Date of Birth ____________ Does this member have medical insurance? Yes☐ No ☐

First Name: ________________ MI_____ Last Name: ________________
Date of Birth ____________ Does this member have medical insurance? Yes☐ No ☐

Membership Annual Fees

Plan Types	**Group Annual Fees**
GROUP DISCOUNTED RATE	$ 40

No Cash Payments
Acceptable methods of payment: ☐ Check ☐ Money Order

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card: #______________________ Expiration Date _______ Security Code______

Signature of cardholder______________________ Date__________

Office Use Only			
Base Code		Track Code	

Mail To:
PHI Cares
2800 N 44th St Suite 800
Phoenix, AZ 85008

CALL TOLL-FREE
1.888.421.6111
Mon-Fri 8AM to 4PM (PST)
WWW.PHICARES.COM

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 PHI Cares* at 1.888.IFLYPHI (888.435.9744). If PHI Cares* 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 PHI Cares* Membership program. I have reviewed the PHI Cares* 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 PHI Cares* for any ambulance services and supplies furnished to me by PHI Cares*. 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 PHI Cares*, 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 PHI Cares* 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 PHI Cares* specifying the additional amount due. Failure to notify PHI Cares* 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 "PHI Cares* Air Ambulance Plan Coverage Agreement" as stated in said contract.

X______________________________ Date______________
SIGNATURE OF HEAD OF HOUSEHOLD

X______________________________ Date______________
SIGNATURE

X______________________________ Date______________
SIGNATURE