



CAREFLIGHT MEMBERSHIP APPLICATION

New Membership
 Renewal Membership
 Gift Membership

PLEASE PRINT OR TYPE

Date _____
 Primary Member's Name _____
 Mailing Address _____
 City/State/Zip _____
 Phone _____
 Birthday _____

If you are giving the membership as a gift please complete:

Your Name _____

Address _____

City/State/Zip _____

*Family Members

First Name	Last Name	Relationship	Birthday
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***Family Definition:** Careflight membership covers you, your spouse, and unmarried dependent children under the age of 22. Anyone living at your residence not claimed on your income tax requires a separate membership.

Please read and sign this Membership Agreement

- ❖ For a one-year period, I hereby apply for the Careflight Membership for myself and my dependent family/household members listed on this application.
- ❖ Careflight Membership covers 100% of the cost of emergency Careflight transports.
- ❖ I understand that Careflight will accept insurance payment from my primary insurance carrier as payment in full.
- ❖ For individuals without healthcare coverage the entire cost of the emergency transport will be covered under the membership plan.
- ❖ Patients will be transported to the nearest appropriate medical facility within the service region based on medical condition and family request.
- ❖ Physicians and/or emergency medical personnel responding to the emergency will determine medical need for air ambulance transport.
- ❖ The effective date of the plan will be three working days after the enrollment form and payment are received by the hospital.
- ❖ I hereby transfer my rights for insurance reimbursement from my insurance carrier paid directly to me to Avera McKennan Hospital & University Health Center for coverage of emergency flight charges.
- ❖ Reimbursement is not to exceed standard charges for air ambulance services. I also understand that my membership investment is not tax deductible and availability of immediate service may be affected by adverse weather conditions or aircraft availability.

Signature _____

Payment Methods

Check Number _____ Please Charge my:

Visa Mastercard Discover

Please make check in the amount of \$49.00 Credit Card Number: _____
to the Avera McKennan Careflight Program. Expiration Date: _____
 Signature: _____

Office Use Only:

Received Date _____

Active Date _____

Initials _____