



BEYOND THE CALL



CALIFORNIA AIR AMBULANCE APPLICATION

GROUP NAME: _____

- NEW
 RENEWAL

SEE IMPORTANT NOTICES ON PAGE 2 PRIOR TO PURCHASE

MAIL THIS FORM AND PAYMENT TO: PHI CARES 801-D AIRPORT WAY, MODESTO, CA 95354

Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
 County of Residence _____ Phone (_____) _____
EMAIL(optional) _____

HEAD OF HOUSEHOLD LIST ANYONE ELSE IN YOUR HOUSEHOLD THAT YOU WOULD LIKE INCLUDED

First _____ MI _____ Last _____ Date of Birth _____
 Insurance (Circle one) Yes No

OTHER MEMBER

First _____ MI _____ Last _____ Date of Birth _____
 Insurance (Circle one) Yes No

OTHER MEMBER

First _____ MI _____ Last _____ Date of Birth _____
 Insurance (Circle one) Yes No

OTHER MEMBER

First _____ MI _____ Last _____ Date of Birth _____
 Insurance (Circle one) Yes No

PLEASE ATTACH OTHER PAGES TO INCLUDE ADDITIONAL MEMBERS OF YOUR HOUSEHOLD

MEMBERSHIP ANNUAL FEES

Plan Types*	Individual or Household Annual Fees	Group Annual Fees
With Health Insurance	\$50.00	Call for Details
With No Health Insurance	\$100.00	Call for Details

***Households with mixed insurance coverage majority will make determination.
 (See below for example.)**

i.e. Three with insurance / Two without = \$50 Three without insurance / two with = \$100.00

METHOD OF PAYMENT: VISA___ MASTERCARD___ DISCOVER ___ CVN(3 digit code)_____

CREDIT CARD NUMBER: _____ **EXPIRATION DATE** _____

CHECK___MONEY ORDER_____ Amount Paid \$ _____

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

X _____ Date _____
SIGNATURE