

# AirMedCare Network Membership Registration - Southern Iowa Electric Customers

By applying for membership, I agree to AMCN's terms and conditions. Initials: **X** \_\_\_\_\_ Todays Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

Name as it appears on Southern Iowa Electric: \_\_\_\_\_ Account Number (if known): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Physical Address: \_\_\_\_\_  
If different than mailing

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Tel.: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Tel.: \_\_\_\_\_

Email: \_\_\_\_\_ Your Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Do you live in City Limits Yes  No   
month day year

**Please List Others Living in Household and Date of Birth** (other than yourself)

Name: 1 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Name: 3 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year month day year

Name: 2 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Name: 4 \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year month day year

### 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.

For Air Evac Office Use Only

**TRACK CODE**

5855

## Monthly Membership Payment Option - Southern Iowa Electric

The price for an AMCN household membership will be \$5.00 per month

Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Account Number (if known) \_\_\_\_\_

Primary Tel. \_\_\_\_\_

### Authorization to add \$5.00 per month to Southern Iowa Electric invoice to pay monthly AirMedCare Network Fees.

The price for an AMCN household membership will be \$5.00 per month

- A member's membership will be effective 15 calendar days after receipt by Enerstar Electric Cooperative of the member's first monthly Membership fee and will continue thereafter as long as monthly Membership fees are paid, but will terminate automatically without notice if no monthly Membership fee is received by AMCN from member for a 60 calendar day period.
- A member may discontinue their AMCN membership at anytime by signing a discontinuation notice (as provided by AMCN).
- **Enerstar Electric Cooperative and AMCN are not affiliated.** Enerstar Electric Cooperative is not responsible for any of AMCN's acts or omissions, and AMCN is not responsible for any of Enerstar Electric Cooperative's acts or omissions. All AMCN membership relationships are directly between AMCN and its members.

By signing this authorization I agree to the terms stated above and acknowledge that I authorized to have the additional \$5.00 AMCN fees added to my residential account. I also understand that I will communicate directly with AirMedCare Network for Membership Member Service.

**X** \_\_\_\_\_  
Member Signature

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

For Air Evac Office Use Only

PLAN CODE

4361

## AirMedCare Network Annual & Multi-Year Membership Payment Options

(Select One)

Platinum (25 Year) Membership* <small>(Multi-year memberships are not available in Indiana or California)</small>	Entire Household	\$1125	<input type="checkbox"/>
10-Year Membership* <small>(Multi-year memberships are not available in Indiana or California)</small>	Entire Household	\$550	<input type="checkbox"/>
5-Year Membership* <small>(Multi-year memberships are not available in Indiana or California)</small>	Entire Household	\$275	<input type="checkbox"/>
3-Year Membership* <small>(Multi-year memberships are not available in Indiana or California)</small>	Entire Household	\$165	<input type="checkbox"/>
1-Year Membership	Entire Household	\$55	<input type="checkbox"/>

Check or money order made payable to: AirMedCare Network

PO Box 948, West Plains, MO 65775

One Time transfer from checking account or credit card

**Total Amount** ..... \$ \_\_\_\_\_



Credit Card Number \_\_\_\_\_ Expires \_\_\_\_\_ 3 digit code on back of card \_\_\_\_\_

**X** \_\_\_\_\_  
Signature

### Bank Information (required for automatic transfers from checking account)

Name on bank account \_\_\_\_\_ routing number \_\_\_\_\_ account number (please attach a voided check) \_\_\_\_\_

**Statement of Authorization** I authorize AirMedCare Network to initiate the EFT withdrawal as indicated above. I may change or cancel this payment by notifying AirMedCare Network in writing. All notifications must be received by the first of the month in order to alter the month's transaction. 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 AirMedCare Network of its termination.

For Air Evac Office Use Only

PLAN CODE

8993

**X** \_\_\_\_\_  
(Signature required)