



# Individual/Family Membership Application

**Important Note: Medicaid recipients are not eligible**

## Primary Applicant For Office Use Only:

<input type="checkbox"/> M <input type="checkbox"/> F	Last Name	First Name	<b>Member ID #</b>	
Mailing Address		City	State	Zip
County				
Date of Birth		Phone No		
Medicare No.		Email Address		

Spouse	Household Member's Information <i>If additional space is needed, please use a separate sheet.</i>			
Last Name <input type="checkbox"/> M <input type="checkbox"/> F	Last Name <input type="checkbox"/> M <input type="checkbox"/> F	First Name & Middle Initial	Date of Birth	
First Name	Last Name <input type="checkbox"/> M <input type="checkbox"/> F	First Name & Middle Initial	Date of Birth	
Date of Birth	Last Name <input type="checkbox"/> M <input type="checkbox"/> F	First Name & Middle Initial	Date of Birth	
Medicare No.	Last Name <input type="checkbox"/> M <input type="checkbox"/> F	First Name & Middle Initial	Date of Birth	

## Primary Health Insurance Information Other than Medicare *This section must be complete for membership renewal*

Insurance Company		Policy or ID Number
Carried through (Employer, Union)		Group Number
Is Family Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Spouse Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Company Phone Number
Insurance Company Address, City State, Zip		

## Spouse Health Insurance Information Other than Medicare *This section must be complete for membership renewal*

Insurance Company		Policy or ID Number
Carried through (Employer, Union)		Group Number
Is Family Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Spouse Covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Company Phone Number
Insurance Company Address, City State, Zip		

## Payment Options *Important Note: Must be signed to be valid*

Sign me up for one year, \$49  
  2 years, \$79  
  3 years, \$109  
  4 years, \$139  
  5 years, \$149  
  \$25 First Responder Rate (Law Enforcement, EMS, Fire Service) Organization:

Personal check or money order enclosed. Please make the payable to Halo-Flight, Inc., 1843 FM 665, Corpus Christi, TX 78415

Charge credit card (\$3.00 Processing fee on all credit card charges):
  Visa  
  MasterCard  
  American Express  
  DISCOVER Discover

Name on Credit Card	Card No.	Exp. Date
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## Membership Agreement *Important Information:*

This Agreement covers myself, my spouse and my children under 19 years of age who live at my residence for a period of 12 months from receipt of payment and are listed on my Application, so long as they remain full-time residents of the specified household. New residence family members may be added, family members may be deleted or the household location may be changed by written notice to Halo Flight, Inc. Added members will be effective immediately as of the postmarked date on the envelope. I understand that Medicaid recipients are not permitted to enroll in this program.

I understand that I am responsible for payment for any services provided to me by HALO-Flight, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those HALO-Flight services specified in this Agreement. This benefit is subject to certain limitation specified in this Agreement. As a condition of receiving this benefit, I hereby assign (hand over) to HALO-Flight all rights and benefits that I or the other family members of my residence have, under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for air ambulance services. Such payment sources are collectively referred to in this agreement as 'insurance.' I authorize payment of all insurance benefits or payments to HALO-Flight. I understand that HALO-Flight will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance, up to the amount of HALO-Flight's charges for its services. When requested by HALO-Flight, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receives any insurance or other third party payments for services provided by HALO-Flight, I will promptly forward those payments to HALO-Flight at 1843 FM 665, Corpus Christi, TX 78415.

How did you learn about the Guardian Plan?  
 HALO-Flight Representative/Presentation  
 Caller.com  
 Other:

I have read and understand the membership agreement above.

MEMBER'S SIGNATURE (Required for Membership)	DATE
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**Upon receipt of your application and payment, an identification card will be mailed to you. Please allow 4 to 6 weeks for delivery.**