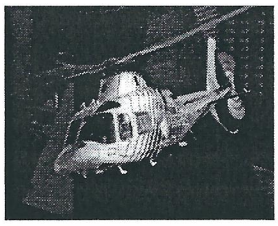
CareFlite
Making precious minutes count since 1979

3110 S. Great Southwest Pkwy
Grand Prairie, Texas 75052
(877) 339-2273 Membership
Fax: 972-660-8821



Caring – Heart Membership Application Bethany SUD

Bethany Special Utility District & CareFlite have partnered together to allow all customers of the water system to become members of CareFlite for $1 per month. This includes all permanent family members of your household at no additional cost as listed below. Filling out this application is not required by the agreement but by doing so, CareFlite is able to provide you with better service if you are transported.

First Name:_____Middle Initial:_____Last Name: _____

Mailing Address: _____

City:_____Zip Code:_____Phone # (_____) _____

Date of Birth: _____ □ Male □ Female

Do you have health insurance? □ Yes □ No If you answered Yes to this question, please list your primary health insurance company:

_____

Other Family Members of Your Household:

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ □ Male □ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth:_____ □ Male □ Female

(For additional household family members, please copy this page and attach to this application)

By submitting this application, I agree (on my behalf and on behalf of my family) in consideration of the benefits provided to abide by the terms of the Caring-Heart Membership Program, which are shown on the back of this application. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to CareFlite for any emergency services and supplies furnished to me or my household family members by CareFlite. I authorize any holder of any of my medical information or that of my household family members to release that information to CMS, its agents or carriers, or CareFlite in order to determine benefits payable on my behalf or on behalf of my family members, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign. **I understand that under Texas rule 157.11 if I or a household member is a Medicaid recipient, than I am not allowed to have them on this application.** Therefore I am stating that I have not listed on this application anyone that is a Medicaid recipient. If a household family member subsequently becomes a recipient of Medicaid, I will notify CareFlite in writing of this change immediately. I warrant that all of the information on this application is true and correct. CareFlite reserves the right to request documentation to verify the accuracy of any such information. I acknowledge that membership in CareFlite's Caring-Heart Membership Program is an EMS membership in a program sponsored by CareFlite and is not a membership in CareFlite's non-profit entity as the term "membership" is contemplated under the Texas Non-Profit Corporation Act.

_____
Signature

For CareFlite Office Use Only

Date Received: _____ Membership # Assigned: _____