CareFlite
3110 S. Great Southwest Parkway
Grand Prairie, TX 75052
Fax (972) 352-6634

Caring-Heart

CareFlite's Membership Program for Granbury Independent School District

(877) 339-2273

First Name: ______________________________ Middle Initial: ___ Last Name: ________________________________

Home Address: ____ City: _____________________________________

Zip: _____________ County: _______________________________ Home Phone #: ____________________________

Date of Birth: _____________ □ Male □ Female

Employer Name: ____

Primary Insurance: □ No □ Yes, if yes, Insurance name _________________________________

Supplement Insurance: □ No □ Yes, if yes, Insurance name _________________________________

Other Family Members of Household *(For additional household family members, please copy this page and attach to this application).*

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: ________________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: ________________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: __________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: __________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: __________________________

By Paying the CareFlite Membership fee I agree (on behalf of my family) to abide by the terms and wish to hereby apply for Air Membership in the CareFlite Caring Heart Membership Program for myself and members of my household listed on the Application, as set forth in this Agreement. I have reviewed the Caring-Heart Air Membership 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 be paid to CareFlite for any emergency services and supplies furnished to me by CareFlite. I authorize any holder of any of any of my medical information to release that information to the CMS, its agents and carriers, or CareFlite, 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 the other members of my household, if they are minors or otherwise unable to sign. I understand that under the State rule 157.11 k, if I or a household member is a Medicaid recipient, then I am not allowed to have them on my Application, therefore, I am stating that I have not listed on my application anyone that is a Medicaid recipient. If a family member becomes a recipient of Medicaid, I will notify CareFlite in writing of this life change immediately. I warrant that all the information in the Application is true and correct. CareFlite reserves the right to request documentation demonstrating the accuracy of such information. I acknowledge that membership in CareFlite Caring-Heart Membership Program is simply a membership in a program sponsored by CareFlite, and thus, is not membership in CareFlite's non-profit corporate entity as the term membership is contemplated under the Texas Non-Profit Corporation Act.

For CareFlite Office Use Only:

Date Received: _________ Form of Payment: ________ EE ID# ________

Amount Paid: _____________ Membership Number Assigned: __________________