Protect Your Family & Finances... Special Offer for Fannin Co. Electric Customers

5 Mail This Application To:

CareFlite
3110 S. Great SW Pkwy
Grand Prairie, TX 75052
(877) 339-2273

CARING HEART MEMBERSHIP

Fannin Co. Electric Coop Customers

__5 Year $75
__4 Year $70
__3 Year $55
__2 Year $40
__1 Year $25

1 Select # of Yrs

2 Fill out the application below:

First Name:_____Middle Initial:_____Last Name: _____

Home / PO Box Address:_____City: _____

Zip:_____County:_____Phone #: _____

Date of Birth:_____ □ Male □ Female Email:_____@_____.____

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: _____

DO NOT SEND CASH **3 Send Check Equal to Number of Years Price or Apply by Credit Card**
If applying by credit card, application can be faxed to (972) 602-7182

Card Type_____Security Code:_____Card Number _____

Expiration Date_____Billing Zip Code_____Name on Card _____

Signature for Processing and / or Acknowledgement of Rules _____

Date _____ **4 All applications Must Be Signed Here**

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.

CareFlite Office Use:

Date Received:_____ Form of Payment:_____Amount Paid: _____

Membership # Assigned:_____ Date Mailed:_____Emp Initial: _____