Membership Enrollment

To enroll by phone, call 800.793.0010 or online at www.AirMedCareNetwork.com

By applying for membership, I agree to AMCN's terms and conditions on the reverse side.	Initials	Today's Date
		/ /

STEP 1 Member Contact Information (please print)

First Name	Last Name	
Mailing Address		
City	State	Zip
Physical Street Address (If different from above)		
City	State	Zip
County	Home Phone	
Date of Birth / /	Cell Phone	
E-Mail Address In order to sign up with recurring payment options, you must provide a valid email address.		
Do you live within the city limits? Yes ❑ No ❑		

STEP 2 List Additional Members In Household

First Name	Last Name
Date of Birth / /	
First Name	Last Name
Date of Birth / /	
First Name	Last Name
Date of Birth / /	
First Name	Last Name
Date of Birth / /	

For customer service inquiries please call:
800.793.0010 or fax changes to 866.299.3303

Membership enrollment forms may be mailed to:
AirMedCare Network, PO Box 948, West Plains, MO 65775

REACH CO,WY,MT

For Office Use Only

GET CODE	TRACK CODE	PLAN CODE
679	13820	

STEP 3 Choose a Membership Option (select one)

Household Membership Type	Cost
❑ Platinum (25 Year) Membership*	$1125
❑ 10-Year Membership*	$575
❑ 5-Year Membership*	$300
❑ **3-Year Membership*** **More Members Choose**	**$185**
❑ 1-Year Membership	$65
❑ Monthly Membership*	$6

*Multi-year memberships are not available in Indiana or California
‡Monthly membership is only available with monthly recurring payment option

STEP 4 Choose a Payment Option (select one)

❑ Check or money order made payable to:
AirMedCare Network
PO Box 948, West Plains, MO 65775
#_____ Check or Money Order Number

❑ One Time transfer from checking account or credit card.
○ VISA ○ MasterCard ○ ○

Bank Information (required for monthly membership option and automatic transfers from checking account)

Name on bank account (please attach a voided check)

Routing number _____ Account number (please attach a voided check)

Credit Card Number _____ Expires

X _____ Signature _____ 3 digit code on back of card

Automatic Withdrawal Authorization

Convenient, automatic renewal of your yearly membership.

○ Recurring ***annual*** credit card payment or automatic transfer from checking account. Please make my recurring payment each year on this date: ____/____ month day

○ Recurring ***monthly*** credit card payment or automatic transfer from checking account. Please make my recurring payment each month on this day: ____ day

Statement of Authorization I authorize AirMedCare Network to initiate the recurring credit card charge or EFT withdrawal as indicated above. I may change or cancel this recurring 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.

X_____ (Signature required for recurring payment option) ____/____/____ month day year