

It's easy to enroll: **GO ONLINE** to [www.REACHair.com/membership](http://www.REACHair.com/membership). **MAIL** completed application with enrollment fee to address above. **FAX** completed application with credit card information to 707 324-2487.

**Application for** (select one):     New Membership                       Renewal  
**Membership Type** (select one):     Group Individual - \$35                       Group Family - \$35

**Group Name:**                                      **Fort Ross Volunteer Fire Department (FRVFD)**  
 Group Name/Affiliation:                      **FRVFD**  
 Coordinator's Name:                              **Stephanie Endsley, PO Box 129, Cazadero CA 95421**  
 Coordinator's Phone Number:                      **(707) 847-3698**  
 Coordinator's Email:                              **stephanie@delaplaine.com**  
 Membership Dates:                              **11/15/2009 – 11/15/2010**

**Primary Member Information (or Gift Recipient Information—please complete all information you know for gift membership.)**

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security Number (last 4 digits only) \_\_\_\_\_ Gender  M  F

Family Information	Name	Relationship to Primary Member	Date of Birth	Gender
Family Member 1	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Family Member 2	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Family Member 3	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Family Member 4	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Health Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Member ID # \_\_\_\_\_

Best way to contact member?     Email     Mail     Phone    Would you like to receive our health-related newsletter?     Yes     No

**Billing Name and Address (if different than above)**

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

**Payment Information** (Please check preferred method of payment)     Check or Money Order (payable to REACH for Life)  
 Please charge my credit card:     VISA     MasterCard     American Express     Discover Card  
 Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Security Code (last 3#s on back of card) \_\_\_\_\_  
 Name (as it appears on credit card) \_\_\_\_\_

Membership cards will be mailed approximately 14 days after we receive your application and payment. Membership cards are not required to receive service. **Your canceled check, credit card statement or money order receipt is your proof of payment.**

• **BEFORE YOU PURCHASE:** If you are currently enrolled in a health maintenance organization (HMO) or other health insurance program, the benefits provided by REACH for Life may duplicate the benefits provided by your current plan. Before purchasing REACH for Life coverage, it is recommended you call your health plan provider to determine if you are covered for this service. • **WARNING:** REACH for Life is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur if REACH is unable to perform within a medically appropriate timeframe due to certain weather conditions, or mechanical/out-of-service issues, or when committed to another call. REACH for Life membership only applies to emergency air medical transports by REACH or a REACH service partner. REACH reserves the right to cancel an individual membership or REACH for Life membership program at any time. • **COMPLAINTS:** For complaints regarding REACH Air Medical Services, first attempt to call us at 866 767-3224. If your complaint is still unresolved, you may contact the Department of Managed Health Care at 800 400-0815 or visit their website at <http://www.dmhc.ca.gov>.

**To confirm agreement to conditions of membership in the REACH for Life program, please check "I agree" box below, sign, date and return this application with your payment. REACH membership will only be valid with this signature.**

I agree     I do not agree    Signature \_\_\_\_\_ Date \_\_\_\_\_

For more information, call REACH for Life weekdays from 8 a.m. to 5 p.m. PST at 866 767-3224 or visit our website at [www.REACHair.com](http://www.REACHair.com).