



DIAMOND MEMBERSHIP APPLICATION (AGE 75 THROUGH AGE 84)

- Step 1.** Complete the information on pages 1, 2 and 3. **Include patient's name and address; sign and date page A.**
- Step 2.** Mail or take the *Physician's Medical Statement* (pages A and B) to your physician(s) and have him or her complete it, front and back, and **return it to you.** **A recent physical (within the last 8 months) must have been completed.**
- Step 3.** Attach photocopy of current passport or driver's license for each member.
- Step 4.** Mail or fax **all** completed pages (1-3, A and B) to **1-800-447-2263**.

Note: We must have all pages requested in order to process your enrollment. Please allow 5-7 business days to process the application.

Member benefits are available worldwide when traveling 150 miles or more from your primary residence but may be limited in countries where U.S. Department of State travel restrictions apply. This membership is nonrefundable and nontransferable. Membership benefits provide for up to 90 consecutive days per trip outside the U.S., Canada or Mexico. **Membership must be activated prior to initial departure from primary residence.**

*Primary residence listed on page 1 determines mileage eligibility for membership benefits. Members must be hospitalized 150 miles or more from this address.

THIS IS NOT AN INSURANCE POLICY. THIS IS A MEMBERSHIP PROGRAM.

MEDJETASSIST DIAMOND MEMBERSHIP

1

Enrollment Application

PRIMARY MEMBER INFORMATION

Mr. Mrs. Ms. Dr. Rev.
Name _____
Date of Birth _____/_____/_____
Passport # _____ Exp. Date _____
Or Driver's License # _____
*Primary Residence _____
City _____ State _____ ZIP _____
Mailing Address _____
City _____ State _____ ZIP _____
Daytime Phone (_____) _____
Evening Phone (_____) _____
Email Address _____
Email Address _____

SPOUSE/PARTNER INFORMATION

Name _____
Date of Birth _____/_____/_____
Passport # _____
Expiration Date _____

PAYMENT INFORMATION

Diamond Membership Annual Fee: \$450.00
Diamond Membership with Spouse/Partner under age 75: \$665.00
Diamond Membership for both Spouses/Partners**: \$855.00
**Pages 2, 3, A and B must accompany for each
Add MedjetAssist *ELITE* to my Membership: \$139.00

Total Amount: \$ _____

For international trips over 90 consecutive days please call for pricing information.

I have read the Diamond Membership Program Rules and Regulations and acknowledge my membership is subject to the Rules and Regulations in effect at the time of enrollment or renewal.

Signature Required: _____

I have enclosed a check payable to MedjetAssist
 Charge to my credit card MasterCard Visa American Express Discover

Credit Card No. _____ Exp. Date _____ Security Code _____

Print Full Name as Shown on Credit Card _____

AGENT INFORMATION

Referred by/Agent Name Good Neighbor Insurance Agent I.D. or Plan# _____

MEDJET ASSIST DIAMOND MEMBERSHIP GENERAL HEALTH QUESTIONNAIRE

2

For your Diamond Membership to be completed the following health questions must be answered fully and truthfully to the best of your knowledge and belief, and all of the health information (including routine physical exams) must be provided. MedjetAssist must approve this application. No one may change this requirement in any way.

In the last five years have you been treated for, had symptoms of, or been advised or counseled that you have had or may have the following:	✓ YES	✓ NO
1. Chest pain, high blood pressure, heart attack, heart murmur, stroke or other disorder of the heart or circulatory system?		
2. Convulsions, epilepsy, paralysis, mental or nervous system disorders?		
3. Asthma, allergies, emphysema, bronchitis, tuberculosis or any other chronic respiratory disease?		
4. Jaundice, intestinal bleeding, ulcer, chronic colitis, diverticulitis, or other liver or gastrointestinal disorder?		
5. Complicated hysterectomy, disorder of the breast or other female organ?		
6. Disease of the kidney, bladder, prostate, or sugar or protein in the urine?		
7. Loss of vision, amputation, deformity, arthritis, or any disorder of muscles, bones or joints?		
8. Cancer, tumor, diabetes or glandular disorder?		

OVER THE PAST 12 MONTHS, HAVE YOU:

1. Had a medical examination, treatment or consultation with a doctor or been confined to a hospital for any condition listed above?		
2. Been placed on a prescribed medication or on a special diet for any condition listed above?		
3. Had a change to a prescribed special diet or medication for any condition listed above?		
4. Been advised to have any diagnostic test, hospitalization or surgery for any condition above?		

All "YES" answers must be explained on page 3

MEDJET ASSIST DIAMOND MEMBERSHIP GENERAL HEALTH QUESTIONNAIRE

Please provide details in the space below for all "YES" answers given on page 2.

QUESTION NUMBER	DETAILS OF CONDITION	DATE OF CONDITION	NAME, ADDRESS AND TELEPHONE OF TREATING PHYSICIAN

Please list any additional medical conditions or issues that this application does not specifically cover for this patient:

**MEDJETASSIST DIAMOND MEMBERSHIP
PHYSICIAN'S CONFIDENTIAL MEDICAL STATEMENT**

A

(A separate statement should be completed for each specialist named on page 3.)

If any of the information is misstated or omitted, membership benefits may not be provided. MedjetAssist reserves the right to terminate membership and/or deny benefits at any time, in its sole discretion, in the event an applicant or member provides false or misleading information about his or her age, health or past medical history.

I have applied for enrollment in the MedjetAssist Diamond Membership program for persons from 75 through 84 years of age. This membership provides hospital-to-hospital medical transportation should I require admission to a hospital while traveling. The following information must be received by MedjetAssist prior to the acceptance of my membership. Please return the completed statement to me.

PATIENT'S NAME: _____
ADDRESS: _____

You have my consent to release the information requested on this form to MedjetAssist, LLC.

→ _____ → _____
PATIENT'S SIGNATURE (REQUIRED) DATE SIGNED (REQUIRED)

Please supply the following information about your patient:

1. What date was the patient last seen (must be within last 8 months)? _____

2. Is the patient under treatment for any condition that would restrict physical activity or travel? Yes ____ No ____

If yes, please describe the condition.

3. Has the patient's medication, diet or treatment plan been modified within the past 12 months? Yes ____ No ____

If yes, please provide how the treatment plan has been changed.

**MEDJETASSIST DIAMOND MEMBERSHIP
PHYSICIAN'S CONFIDENTIAL MEDICAL STATEMENT**

B

4. Has the patient been admitted to the hospital in the past 12 months or had any outpatient procedure(s) over the last 12 months? Yes ____ No ____

If yes, please provide the reason for the hospital admission, length of stay, date of stay, follow-up course of treatment if needed, and type of procedure(s) performed.

5. Is the patient under treatment for any condition requiring periodic hospital admission or specialized medical care? Yes ____ No ____

If yes, please describe the condition and indicate approximate frequency of hospital admissions.

6. In your opinion is the patient in generally good health and physically and mentally able to engage in unrestricted domestic or foreign travel, including travel in pressurized aircraft? Yes ____ No ____

Comments:

PHYSICIAN'S SIGNATURE

DATE

Print or Type Physician's Full Name and Address

Telephone Number

FOR MEDJETASSIST OFFICE USE ONLY

Level One Review: Received _____ Approved _____ Approved w/Exclusions _____ Disapproved _____
Level Two Review: Received _____ Approved _____ Approved w/Exclusions _____ Disapproved _____

Notes

Please be advised of the availability of Medjet's Notice of Privacy Practices. The HIPAA Privacy Rule gives you the right to be informed of Medjet's privacy practices as well as your rights with respect to your personal health information. You may obtain a copy of Medjet's Notice of Privacy Practices in the following ways:

- Visit our website, www.medjet.com, and click on the "Notice of Privacy Practices" link.
- Email us at HIPAA@medjet.com to request a copy be emailed to you.
- Send a request to the following address to receive a copy by mail:

HIPAA Official
Medjet Assistance, LLC
P.O. Box 43099
Birmingham, AL 35243