

# Membership Registration

**New**

**Renewal**

**Gift**

Name \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ DOB \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_ Insurance Carrier Phone Policy No. \_\_\_\_\_

**Family members for program**  
(Use additional sheet if necessary)

(First Name) (Last Name) (Relationship) (Birth date)

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Hospital Wing Membership covers immediate family: Legally married husband and wife and children to age 21 years being claimed on income tax or a full-time college student to age 23 years. Grandchildren are eligible if the grandparent has legal guardianship or power of attorney.

Hospital Wing registration is not insurance. After all insurance payments are made to Hospital Wing, the patient will not owe any additional payments. For Hospital Wing Members, Hospital Wing will accept payment from insurance as payment in full from a Hospital Wing flight. By my signature below I agree to transfer directly to Hospital Wing my rights to air medical insurance payments due me. Such payments shall not exceed regular Hospital Wing charges.

**No refunds on membership purchases. Membership does not cover ground ambulance services.**

Hospital Wing transports patients up to 300lbs, or a girth ratio of 27 inches. Hospital Wing cannot guarantee transports on patients exceeding this weight limit. Other appropriate operational flight considerations must be met for transport (i.e. weather, mileage to include coverage area, etc.).

## Membership Fees

(Please select one)

**Individual membership(s)**

1 Year \$50.00

**Family Membership(s)**

1 Year \$60.00

**Payment Method**

Hospital Wing transports patients based on medical need, not membership status and transports patients to the closest, medically appropriate facility as directed by approved parties.

After completed registration with payment is received by Hospital Wing, new member benefits take effect in fourteen (14) days. However, the membership registration will be valid immediately for an unforeseen critical illnesses or incidents requiring emergency transport by Hospital Wing.

Check Enclosed (please make payable to Hospital Wing)

M/C

Visa

Discover

A/E

C/C# \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Code: \_\_\_\_\_

**Mail payment to:**

Hospital Wing  
1080 Eastmoreland Ave  
Memphis, TN 38104