



American Medflight  
SaveAir Application

Insured Applicant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Insured Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Member Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**\*\*Attach Copy of Insurance Cards\*\***

Dependent Family Members:

- 1. \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_
- 2. \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_
- 3. \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_
- 4. \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_
- 5. \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_
- 6. \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Send Check, Money Order or Charge Card Information to:

American Medflight  
P.O. Box 10166  
Reno, NV 89511-0166

Or call Samantha  
775-856-5800 x100

1 year membership: \$45.00

2 year membership: \$85.00