Business Name: Fern Ridge School District Effective Date:_____ Employee ID #:_____

MASA MEMBER INFORMATION

NAME (Last, First, Middle):_____ DOB:_____/_____/_____

SPOUSE (Last, First, Middle):_____ DOB:_____/_____/_____

Physical Address:_____ City/State/Zip:_____

Mailing Address (if different):_____ City/State/Zip: _____

Phone: (_____) -_____-_____ Alt. Phone: (_____) -_____-_____ Email:_____

Dependent Name: _____ DOB: _____/_____/_____

Dependent Name: _____ DOB: _____/_____/_____

Dependent Name: _____ DOB: _____/_____/_____

Dependent Name: _____ DOB: _____/_____/_____

Dependent Name: _____ DOB: _____/_____/_____

EMPLOYEE PAYMENT OPTIONS FOR MASA MTS MEMBERSHIP	
Platinum Membership	**Emergent Plus Membership**
____$39 Monthly ($60 Initiation Fee Waived)	____$14 Monthly ($60 Initiation Fee Waived)

☐ I authorize my employer to do a payroll deduction equivalent to the selected amount from my payroll check for my MASA MTS membership. I further understand that in the event that my employment with my employer is terminated, whether voluntarily or involuntarily, my employer has the right to deduct from my final paycheck any amounts paid upfront by my employer that has yet to be deducted from my paycheck(s).

Health Plan Coverage – Select One

☐ I will not be enrolled in high-deductible health plan coverage that is compatible with a health savings account on my membership effective date.

☐ I will be enrolled in high-deductible health plan coverage that is compatible with a health savings account on my membership effective date. *

*No medical benefits will be available under the Membership for expenses incurred prior to the date you have satisfied the applicable statutory minimum deductible under Internal Revenue Code section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.

(Signatures on following page)

By providing my signature below,

- I declare that I have read and agree to the terms and conditions in the Member Services Agreement.
- I provide my signature expressly consenting to contact from Medical Air Services Association, Inc. ("COMPANY") and/or its subsidiaries, affiliates, or agents to contact me regarding products or services via live, automated or prerecorded call, text, or email, or regular mail. I understand that I am not required to enter into this consent as a condition of purchase. I can revoke this consent by calling 1-800-643-9023.
- I declare that I understand and acknowledge that if I am enrolled in high-deductible health plan coverage that is compatible with a health savings account on my membership effective date, no Internal Revenue Code ("IRC") section 213(d) medical care benefits will be available under the Membership for expenses incurred prior to the date I have satisfied the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.
- For the Emergent Plans, the Member acknowledges and agrees that the Services provided hereunder are meant exclusively to supplement Member's health and/or other insurance coverage(s). For that purpose, in the event that Member fails to carry primary health insurance at time of claim, MASA shall be liable to Member for no more than 20% of Member's Out-of-Pocket Expenses, but in no event will MASA pay more than twenty-thousand dollars ($20,000), per claim.

*THIS AUTHORIZATION REMAINS IN FULL FORCE AND EFFECT AND THIS MEMBERSHIP WILL RENEW AUTOMATICALLY UPON EXPIRATION OF THE MEMBER'S INITIAL MEMBERSHIP TERM FOR A TERM EQUAL TO THE INITIAL MEMBERSHIP TERM UNLESS CANCELLED IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THIS MEMBERSHIP.

► _____ _____ _____

Employee's Signature **Name** (Print) **Date**

MASA MTS Rep	Other
Tony Urioste	WHA Insurance