Medjet®

Take Trips. Not Chances.

MEDJET IS NOT INSURANCE. WE'RE DIFFERENT, AND HERE'S WHY.

Medjet is the premier air medical transport and travel security membership program for travelers. Most travel insurances and platinum level card programs only get you to the "nearest acceptable facility." Medjet can get you all the way home – **regardless of medical necessity**. With **no deductibles**, **no claim forms** and **no monetary caps** on air medical transport costs, Medjet memberships provide travelers with unrivaled control over their health and safety.

MEDJET MEMBERSHIP OPTIONS & BENEFITS:

MEDJETASSIST *Air Medical Travel Protection*

As a MedjetAssist member, if you become hospitalized 150 miles or more from your residence address – internationally or domestically – Medjet will arrange medical transport to the hospital of your choice in your home country for continued inpatient care. Additional benefits include transfer of mortal remains and access to a physician via phone if you become ill or injured while traveling. **Covid-19 Transport is covered** with some restrictions. Benefit details are available at **Medjet.com/COVID**.

MEDJETHORIZON *Medical Transport, Security, Crisis Response*

In addition to the medical transport benefits of MedjetAssist, MedjetHorizon members gain access to an unprecedented suite of security, health, and travel services. Additional benefits include ground ambulance transfer, personal travel advisories and emergency medical cash advance. MedjetHorizon offers a 24/7 crisis response center staffed by veteran security experts, powered by FocusPoint International, who provide crisis consultation and coordinated in-country response services related to the following events:

- *Violent Crime*
- *Terrorism*
- *Natural Disaster*
- *Kidnapping for Ransom*
- *Disappearance of Persons*
- *Political Threat*
- *Hijacking*
- *Pandemic*
- *Blackmail and Extortion*
- *Wrongful Detention*

If you live in the United States, Canada or Mexico, Medjet has a membership for you. We protect individuals and families, corporations and non-profits, students, expatriates and more.

For those age 75 to 84, our **Diamond Annual Membership** protects you during domestic and international travel less than 90 consecutive days. If any of your international trips exceed 90 days at one time, you would be eligible for one of our Diamond Expat Memberships.

Diamond Expat Memberships protect you up to 180 or 365 days per trip. Once your travels bring you back to your home country, the daily count starts over so you can travel again within your membership term.

Both Diamond memberships are limited to one medical transport per year. For Diamond members, we require a **General Health Questionnaire and Physician's Medical Statement** to be submitted for approval. Approval can take 5-7 business days. A spouse/partner may be added to your membership if they are age 84 and under, within appropriate membership terms.

Diamond Annual Membership | start at $470
Diamond Expat180 | start at $790
Diamond Expat365 | start at $1,230

800.527.7478 (Phone) • 800.863.3538 (Fax) • Diamond@Medjet.com

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Bushtracks African Expeditions - Agency ID# 3318

Diamond Membership Instructions

(Age 75 through Age 84)

STEP 1. ☐ Complete the information on pages 1, 2, & 3.

☐ Does each question on pages 2 and 3 have either a YES or NO answer?

☐ For each YES answer on pages 2 and 3, did you provide the date and requested details?

☐ Did you complete the OPTIONAL HIPAA waiver form?

STEP 2. ☐ The Physician's Medical Statement (pages A and B) must be answered by your primary care physician, who has performed an evaluation within the last 12 months. In addition, a separate medical statement should be completed for each specialist seen within the last 12 months named on pages 2 and 3.

☐ Sign and date page A.

STEP 3. ☐ Send the **completed** application to Medjet.

Mail to: P.O. Box 43099 • Birmingham, AL 35243
UPS/FedEx: 3075 Healthy Way • Birmingham, AL 35243
Email to: Diamond@Medjet.com
Fax to: 800.863.3538 or 205.595.6658

Note:

- **We must have ALL pages requested in order to process your application.**
- **Please allow 5-7 business days for application to be reviewed.**
- **Medical information provided on this application is only valid for 60 days.**

Member benefits are available worldwide when traveling 150 miles or more from your Residence Address but may be limited in countries where U.S. Department of State travel restrictions apply. This membership is nonrefundable and nontransferable. For international trips over 90 consecutive days, please call for information and pricing on DIAMOND EXPAT180 and DIAMOND EXPAT365 Medjet memberships.

MEDJET DIAMOND MEMBERSHIP
ENROLLMENT APPLICATION

1

DIAMOND APPLICANT INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Rev. **NAME** _____ **D.O.B.** _____ / _____ / _____

WORK ( ) _____ - _____ HOME ( ) _____ - _____ MOBILE ( ) _____ - _____

EMAIL _____ *A Medjet representative may contact you.

SECONDARY EMAIL _____ ☐ **Yes, I would like to receive the Medjet eNewsletter.**

RESIDENCE ADDRESS

STREET ADDRESS _____ CITY _____ STATE _____ ZIP_____

NOTE: Residence Address determines mileage eligibility for membership benefits. Members must be traveling 150 miles or more from this address.

MAILING ADDRESS (If different from above)

ADDRESS _____ CITY _____ STATE _____ ZIP_____

SPOUSE/PARTNER INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Rev. **NAME** _____ **D.O.B.** _____ / _____ / _____

MEMBERSHIP OPTIONS

FROM THE FOLLOWING ANNUAL MEMBERSHIP OPTIONS, SELECT ONE:

	USD
INDIVIDUAL DIAMOND MEMBERSHIP	☐ $470.00
with upgrade to MEDJETHORIZON (optional)	☐ $629.00
DIAMOND MEMBERSHIP + SPOUSE/PARTNER, UNDER AGE 75	☐ $695.00
with upgrade to MEDJETHORIZON (optional)	☐ $884.00
DIAMOND MEMBERSHIP + SPOUSE/PARTNER, AGE 75-84*	☐ $890.00
with upgrade to MEDJETHORIZON (optional)	☐ $1079.00

**If your spouse/partner is age 75-84, pages 2, 3, A and B must also be completed for your spouse/partner.*

By enrolling in a membership, I acknowledge the membership is subject to the Rules and Regulations in effect at the time of enrollment. The current Rules and Regulations are available online at Medjet.com and will be included in your membership packet.

Membership must be approved and payment received prior to initial departure from Residence Address.

PAYMENT INFORMATION

☐ **I HAVE ENCLOSED A CHECK PAYABLE TO:** *Medjet*. **USD ONLY.**

☐ **CHARGE TO MY CREDIT CARD:** ☐**VISA** ☐**MASTERCARD** ☐**AMERICAN EXPRESS** ☐**DISCOVER**

CREDIT CARD NO. _____ **EXP. DATE** _____ **SECURITY CODE** _____ **BILLING ZIP CODE** _____

PRINT FULL NAME AS SHOWN ON CREDIT CARD _____

TRAVEL AGENCY NAME: TRAVEL AGENT'S NAME / EMAIL:

Bushtracks African Expeditions (Agency ID# 3318)

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MEMBER/PATIENT AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the form below if you allow MEDJET the access to discuss your Protected Health Information (PHI) with those listed below. (I.E. spouse, children, assistant, etc.)

_____ Initial here if you choose NOT to allow MEDJET to release your PHI.

I, _____ (Member) hereby authorize MEDJET to disclose and discuss Protected Health Information (PHI) to/with the following individuals via any of the following mediums: hardcopy, electronic or phone.

I understand that these delivery methods pose certain risks to the privacy and security of my PHI that may be beyond the control of MEDJET.

I agree to assume such risks personally, and to hold MEDJET harmless in the event my PHI is breached or compromised as a result of my directing and authorizing MEDJET to transmit or deliver such information electronically or by other means.

Additional health information may be requested by MEDJET from the prospective Member's physician(s). Any cost(s) associated with obtaining this additional information is solely the responsibility of the Member.

_____	_____	_____
(Name)	(Relationship to Member)	(Phone)
_____	_____	_____
(Name)	(Relationship to Member)	(Phone)
_____	_____	_____
(Name)	(Relationship to Member)	(Phone)

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to MEDJET at: HIPAA Official, 3075 Healthy Way, Birmingham, AL 35243

I understand that a revocation is not effective to the extent that MEDJET has relied on this authorization for the use or disclosure of the PHI.

Note that MEDJET will not condition my membership, payment, enrollment or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____

(Signature of Member)

_____

(Date)

Medjet Diamond Membership
General Health Questionnaire

2

For your Diamond Membership to be accepted for review, **all of the following health questions must be answered** fully and truthfully. All of the health information (including routine physical exams) must be provided to Medjet in order for the application to be reviewed.

NAME: _____

IN THE LAST 5 YEARS have you been treated for, had symptoms of, or been advised or counseled that you have had or may have the following:

1. Chest pain, heart attack, heart murmur, stroke or other disorder of the heart or circulatory system? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

2. Convulsions, epilepsy, paralysis, mental or nervous system disorders? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

3. Asthma, emphysema, bronchitis, tuberculosis or any other chronic respiratory disease? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

4. Jaundice, intestinal bleeding, ulcer, chronic colitis, diverticulitis, or other liver or gastrointestinal disorder? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

5. Disease of the reproductive organs? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

6. Disease of the kidneys, breast, bladder, or prostate? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

IN THE LAST 5 YEARS have you been treated for, had symptoms of, or been advised or counseled that you have had or may have the following:

7. Loss of vision, amputation, deformity, arthritis, or any disorder of muscles, bones, or joints? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

8. Cancer or tumor? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

9. Diabetes or glandular disorder? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

IN THE LAST 12 MONTHS have you:

10. Received treatment or consultation with a doctor or been confined to a hospital? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

11. Been placed on a newly prescribed medication? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

12. Been advised to have any diagnostic test, hospitalization or surgery? ☐ **YES** ☐ **NO**

If **YES**, please provide the following details: PHYSICIAN'S NAME: _____ DATE OF CONDITION: _____

DETAILS OF CONDITION: _____

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

Medjet Diamond Membership

Physician's Confidential Medical Statement

A

(A SEPARATE STATEMENT SHOULD BE COMPLETED FOR EACH SPECIALIST SEEN WITHIN THE LAST 12 MONTHS NAMED ON PAGES 2 & 3.)

If any of the information is misstated or omitted, membership benefits may not be provided. Medjet 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 Medjet 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 Medjet prior to the acceptance of my membership. Please return the completed statement to me.

Additional health information may be requested by Medjet from the prospective Member's physician(s). Any cost(s) associated with obtaining this additional health information is solely the responsibility of the Member.

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S PHONE: _____ PATIENT'S EMAIL: _____

PATIENT'S ADDRESS: _____

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

_____ _____

PATIENT'S SIGNATURE (Required) **DATE SIGNED (Required)**

INFORMATION BELOW TO BE COMPLETED BY PHYSICIAN

Please supply the following information about your patient:

1. What date was the patient last seen (must be within last 12 months)? DATE: _____

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.

_____

_____

_____

APPLICANT'S NAME _____

B

Medjet Diamond Membership

Physician's Confidential Medical Statement (cont'd)

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**

If **NO**, please clarify.

_____

_____

_____

PHYSICIAN'S ADDRESS:

_____ PHYSICIAN'S PHONE: _____

_____ PHYSICIAN'S FAX: _____

_____ PHYSICIAN'S EMAIL: _____

_____ _____

PHYSICIAN'S SIGNATURE DATE

_____

PHYSICIAN'S NAME (please print)

FOR MEDJET OFFICE USE ONLY

Received _____ Approved _____ Approved w/Exclusions _____ Disapproved _____