MEDICAL AIR SERVICES ASSOCIATION

MEMBERSHIP APPLICATION **DATE** _____

Name _____
Last First Middle

Spouse _____
Last First Middle

Birth date: Member__-__-__ Spouse__-__-__

Age of primary member _____ Spouse's Age _____

Address _____

Dependents Birth date

_____ ___-___-___

_____ ___-___-___

_____ ___-___-___

City _____State _____Zip _____ Country_____ Phone_____

*Mailing Address _____ City_____ State_____

Zip _____ Country_____ Phone _____

Social Security Number

CURP (Ciudadanos Mexicanos)

_____ ___-___-___ _____
PRE-EXISTING CONDITIONS ARE COVERED AFTER 90 DAYS MEMBER SIGNATURE

Type of Membership	Individual	Family	
Annual Membership	$240.00	$360.00	$
Initiation Fee (first year only)			$ 60.00
Total			$

NOTE: Following hospitalization, MASA will return you to the airport nearest the residence address listed on your MASA membership application.

Please check payment method:

☐ 1. Charge to: ☐ Visa or MasterCard ☐ American Express ☐ Discover

Card Number Expiration Date

[ ] I want automatic renewal on my charge card
INITIALS

☐ 2. Payment authorization faxed to: (USA) 817-491-1368

MASA Representative: _____ Group–[MASA] Rep.#0002051

Medical Air Services Association [MASA]
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www.masamexico.com