

## EXTENDED PLAN APPLICATION

**Since 2004, Global Rescue has been the world's leading provider of medical, security, evacuation and travel risk management services to enterprises, governments and individuals.**

Extended Memberships are for travelers 75 to 85 years of age. For individuals over age 85, medical transport benefits are available on a fee-for-service basis. Please complete this application if you are or will be 75 years of age or older when traveling. If insufficient space, attach additional pages to the form when submitting, i.e. problem list, medication list, etc.

After payment is received, your membership becomes effective on the date indicated during sign up. You will receive an email when your account has been activated. Applications cannot be submitted more than 90 days prior to the membership start date.

For more information regarding Global Rescue membership services, visit [www.globalrescue.com](http://www.globalrescue.com), or call +1 (617) 459-4200.

## INSTRUCTIONS

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1. Indicate your desired membership and requested start date in the Extended Travel Services Membership Plans and Pricing section. Please choose only one.
2. Complete the Personal Information section in full and indicate you agree to the Member Services Agreement and Terms of Service.
3. Answer all six questions in the Medical History and Information section completely and in detail to the best of your ability, including dates of diagnosis and treatment.
  - a. If a question does not apply to you write "N/A" on the line.
  - b. Please attach additional pages to this application if the lines provided do not give enough space for all information.
  - c. Medications list must include the reason for taking.
4. Complete the General Information section completely.
5. Sign the last page of the application.
6. Submit your application by
  - a. **Email:** [memberservices@globalrescue.com](mailto:memberservices@globalrescue.com)
  - b. **Fax:** 617-507-1050
  - c. **Mail to:**  
85 Mechanic Street, Suite A1-1  
Lebanon, NH 03766

### IMPORTANT NOTE

*If the Member omits relevant medical information, is hospitalized due to circumstances diagnosed or treated within one year prior to this application, or for which symptoms existed which would cause a prudent person to seek such diagnosis or treatment, travel benefits may be excluded or denied.*

*Acceptance of this form does not constitute a guarantee of services.*

## EXTENDED TRAVEL SERVICES MEMBERSHIP PLANS AND PRICING (Please choose only one)

INDIVIDUAL ANNUAL MEMBERSHIPS		Medical Only	Medical & Security
Standard (up to 45 consecutive days abroad)		\$699	\$1,399
1/4 Year (up to 90 consecutive days abroad)		\$899	\$1,799
1/2 Year (up to 180 consecutive days abroad)		\$1,099	\$2,199

  

SHORT TERM MEMBERSHIPS		Medical Only	Medical & Security
7 Day Membership		\$259	\$509
14 Day Membership		\$339	\$679
30 Day Membership		\$489	\$979

  

TOTALCARE <sup>SM</sup> MEMBERSHIPS	Max Travel Days	Urgent Care Consults	Telehealth & Medical	Telehealth, Medical & Security
Silver Membership (domestic only)	n/a	1	\$590	n/a
Gold Membership	45	1	\$1,340	n/a
Platinum Membership	90	4	n/a	\$2,540
Unlimited Membership	Unlimited	Unlimited	n/a	\$5,040

REQUESTED START DATE:

\* Shipping and processing charges may apply for the shipment of your Checkme Pro™.

## PERSONAL INFORMATION

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Email\*: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

(\*Use this email to log onto <https://www.globalrescue.com/login.xhtml> to provide further information and research Destination Reports prior to travel.)

YES. I have read and agree to the Member Services Agreement on the Global Rescue website. Date: \_\_\_\_\_

The Membership Services Agreement can be found at <http://www.globalrescue.com/agreement.cfm>.

You will receive an email when your account has been activated. Global Rescue encourages you to log into your account and fill in critical information, such as emergency contacts, health history, etc.

How did you hear about us? \_\_\_\_\_

RP Code: \_\_\_\_\_

# MEDICAL HISTORY AND INFORMATION

1. Do you have any allergies, including any medications? If so, please list them here: \_\_\_\_\_  
\_\_\_\_\_
2. Have you ever been diagnosed and/or treated for any of the following:   None of the below
- |   |                            |   |                                    |
|---|----------------------------|---|------------------------------------|
| High blood pressure                               | Diabetes                   | Rheumatoid disorder                       | Altitude sickness                  |
| Asthma  | High cholesterol           | Stomach problems or ulcers                | Dementia                           |
| Emphysema/ COPD                                   | Angina or chest discomfort | Liver problems including hepatitis        | Cancer                             |
| Sleep apnea<br>I travel with my breathing machine | Heart problems             | Anemia or low blood count                 | Type _____<br>Diagnosis Date _____ |
| Stroke  | Arrhythmia<br>A-fib        | Kidney problems<br>Kidney stones<br>Other | Status _____                       |
| Mental health conditions                          | Thyroid problems           |   |                                    |
3. Please explain any above medical conditions to include **diagnosis and treatment dates**: \_\_\_\_\_  
\_\_\_\_\_
4. Please list any medical conditions not listed above, and include **diagnosis and treatment dates**: \_\_\_\_\_  
\_\_\_\_\_
5. Please list any hospitalizations, surgeries or procedures you have undergone in the last 5 years **with dates**: \_\_\_\_\_  
\_\_\_\_\_
6. Please list any medications you currently take and indicate what you take them for: \_\_\_\_\_  
\_\_\_\_\_

# GENERAL INFORMATION

Trip dates and location: \_\_\_\_\_

Expected activity during travel: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

Do you have a disability?           Yes           No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

We may need to contact your primary care provider before approving your application. Do you consent to Global Rescue and physicians at Elite Medical Group contacting the above-named provider for this purpose? If so, please sign the statement below:

I authorize Global Rescue, LLC, to contact my provider, \_\_\_\_\_, and I further authorize my provider and her/his staff to share my medical history and current health information with Global Rescue, LLC.

As of today's date I am confirming that all of this is up to date information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please download, complete, and save this form.**  
**Please mail application to Global Rescue, 85 Mechanic Street A1-1, Lebanon, NH 03766 or email the completed form to [memberservices@globalrescue.com](mailto:memberservices@globalrescue.com)**