PATIENT SERVICES AGREEMENT

Including Designation of Authorized Representative, Release of Information, & Assignment of Benefits

This Services Agreement ("AGREEMENT") is entered into as of this, date the day of 2025, between patient name, ("PATIENT") and WORLDWIDE AIRCRAFT SERVICES Inc., d/b/a Jet ICU ("Jet ICU").

RECITALS

WHEREAS: Jet ICU, in conjunction with its sub-contractors and certain other third parties is in the business of providing acute life support air ambulance services, basic life support air ambulance services, medical escorts, elder flights, arranging for ground ambulance service, and insurance benefits assistance; and

WHEREAS PATIENT desires Jet ICU's services and agrees to be the responsible party for services under this AGREEMENT for transport of PATIENT from:

origin To

destination.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

I patient name, do hereby designate Jet ICU, its officers, attorneys, accountants, employees, agents and/or representatives to act as my authorized representative (pursuant to 29 CFR § 2560.503-1) in connection with the claims for medical services as referenced above, and to act on my behalf to pursue all claims, appeals (administrative and/or judicial), litigation, or other actions required to obtain insurance reimbursement payments that I am or may be entitled to.

I hereby authorize and convey to Jet ICU to the full extent permissible under law and in relation to any applicable insurance policy and/or employee health care benefit plan the right and ability to: 1) act on my behalf in connection with any claim, right, appeal, or other cause of action

that I may have under such insurance policy or benefit plan; 2) act on my behalf to pursue such claim, right, appeal, or other cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to act on my behalf under the provisions of ERISA as provided in 29 CFR § 2560.503-1; and 3) the right to pursue available legal remedies.

I further authorize Jet ICU to request and receive on my behalf copies of my insurance and plan related documents, including information pursuant to 29 CFR § 2560.503-1 and ERISA Section 104(b)(4)(c) or 29 U.S.C. § 1024(b)(4) and under any and all applicable PPACA regulation.

If my claim is not governed by ERISA, I designate, to the fullest extent possible, Jet ICU, to serve as my authorized representative as is permitted under any insurance policy or benefit plan available to me.

I make this designation and authorization to the fullest extent permissible under applicable state and federal law, as well as applicable policy, so that Jet ICU is entitled to represent me and to act on my behalf as my authorized representative with respect to every aspect of my claim for insurance benefits, including but not limited to the following:

- Directly receive notifications that I am entitled to receive related to my claim.
- Pursue any and all appeals processes related to a claim for medical air or ground transportation, including all levels of administrative appeals, external appeals, and, if necessary, any legal, equitable, or declaratory court action to recover my insurance benefits and/or pursue a claim or claims for penalties against any plan administrator for failure to process or resolve said claim.
- Obtain any and all plan documents, including, without limitation, insurance plan policies, Summary Plan Descriptions, Summary of Benefits & Coverage, and any other documents related to my insurance benefits.
- Release all medical information necessary to process my claim(s).
- Obtain information from any plan administrator, fiduciary, insurer, attorney, and any other person in possession of information sought by Jet ICU to which I am entitled, and to direct that the information be released to Jet ICU to pursue payment of my insurance claim(s) according to my insurance policy and benefits.
- To utilize my signature to obtain insurance benefit information, make claims submissions, and/or obtain any plan documents, medical records, or other information Jet ICU deems necessary to pursue my claim(s).

If my insurer requires a specific person or employee of Jet ICU to be designated as my authorized representative, I hereby designate Michael Brannigan and/or Michael Honeycutt as authorized representatives for the claims and appeals processes.

Federal law expressly prohibits an insurer or related party from precluding or interfering with my rights to designate or assign my healthcare provider as my authorized representative to exercise such protected rights and assist me in this process. 25 CFR Section 2560.503-1(b)(4).

AUTHORIZATION TO RELEASE INFORMATION

I understand that Jet ICU's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I specifically authorize you to discuss and disclose my personal and protected health information (PHI) for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits.

I also specifically authorize my representatives at Jet ICU to release any information necessary to insurance carriers regarding my medical condition(s) and treatment for the purposes of processing insurance claims.

I further authorize my insurer(s), including but not limited to:

Release any of my protected health information (PHI) to the authorized representatives named above for the purposes of billing; claims; resolving said claims, grievances, or appeals; and responding to any request by the authorized representative.

I further understand that the Protected Health Information disclosed (PHI) may no longer be protected by federal health information privacy laws once disclosed.

LEGAL ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

Financial Responsibility

I acknowledge that I have requested medical and ambulance services from Jet ICU on behalf of myself and/or my dependent or those that I am otherwise legally responsible for, and that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I understand that necessary forms will be completed by JET ICU or its

billing agent in order to file for insurance carrier payments. If my cooperation is needed and requested to assist them in the above processes, I agree to cooperate with such reasonable requests. I understand that if I later refuse to cooperate with reasonable requests for documents or signatures required to bill my insurer(s), I may be fully responsible for the entire claim amount.

I understand that I may be responsible for copayments, deductibles, or out of pocket costs determined by my insurance. Jet ICU reserves the right to balance bill.

I understand that I am responsible for any amount not covered by insurance. I further understand that all fees for said services are due and payable on the date services are rendered, and I agree to pay all such charges incurred in full immediately upon
presentation of an invoice or statement, unless other arrangements have been made in advance with Jet ICU.

Assignment of Benefits

I hereby assign all medical and ambulance benefits (air or ground), to include major medical benefits to which I am entitled, to Jet ICU, who is also my authorized representative.

I agree that Jet ICU is permitted to bill all insurance companies or benefit plans from which I may be entitled to benefits for any medical air and/or ground transportation services provided to me. I direct any insurers or health plans to acknowledge and act in compliance with this Assignment.

I further designate Jet ICU as my beneficiary to any rights under my insurance benefits and irrevocably assign to Jet ICU all rights I may have in connection with such benefits.

I hereby authorize and direct my insurance carrier(s), including but not limited to Medicare/Medicaid, private insurers, travel insurers, and/or any other health/medical benefit plan, to issue payment check(s) directly to Jet ICU for services rendered as referenced above to myself and/or my dependent or those for whom I am otherwise legally responsible for, regardless of my insurance benefits, if any.

If my insurance carrier(s) issue payment for the above services directly to me and/or to my guardian(s) and/or my family member(s) or other persons with legal responsibility, I will forfeit all check(s) by making them payable to Jet ICU with proper endorsement, and forwarding such payments to them at the address provided.

Should this assignment be contested or prohibited in any way by the terms of an anti- assignment provision contained in my insurance benefit plan or policy, I request that the insurer advise and disclose to Jet ICU within ten

(10) working days of notice of assignment; otherwise this assignment should be reasonably expected to be effective and any anti-assignment provision is waived.

I understand that if I revoke or attempt to revoke the Assignment of Benefits, I may be fully responsible for the entire claim amount.

WAIVER OF LIABILITY

I, patient name, and my heirs or assigns, do hereby agree to hold WORLDWIDE AIRCRAFT SERVICE Inc., d/b/a Jet ICU, harmless from any liability associated with the services provided by any other entity.

DELAY OR CANCELATION OF SERVICES

I, patient name, understand that circumstances outside of JET ICU's control may arise that could potentially delay or postpone the

performance of the services. Such circumstances may include, but are not limited to, acts of God, inclement weather, worsening of patient condition, etc.

Should PATIENT need to cancel the performance of the services herein, PATIENT agrees to inform JET ICU of the exact reason for such cancellation. Should such cancellation occur or PATIENT expire prior to performance of services, but after repositioning of aircraft, or flight crew mobilization, PATIENT agrees to be financially responsible for such associated costs including but not limited to administrative costs.

OTHER ACKNOWLEDGEMENTS & AGREEMENTS

I understand that neither my health care provider nor my insurer(s) will condition the provision of my care or health plan benefits upon the authorization and assignments contained herein.

This designation shall become effective as of the date of my signature below and shall remain in effect until all claims, appeals, complaints, grievance processes, and/or legal actions related to the referenced medical services are completed by Jet ICU or myself. Unless revoked, this assignment and authorization is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, Medicaid, and other applicable state and federal law(s).

I understand that I may not receive copies of any documents, notices, or other written information that is provided to my authorized representative(s), unless I direct my insurer otherwise.

I acknowledge that my authorization herein is voluntary and will remain

effective unless revoked by me in writing. I have read and fully understand this Designation of Authorized Representative, Release, and Assignment of Benefits. I acknowledge that my authorization herein is voluntary.

A photocopy of this Patient Services Agreement shall be as effective and valid as the original.

Signed on this Day of Month, 2025:

Patient/Responsible Party: {{Sig_es_:signer1:signature}}

Patient Mailing Address: {{*Address_es_:signer1:text}}

Patient City, State, & Zip: {{*CityStateZip_es_:signer1:text}}

Patient Telephone: {{*Telephone_es_:signer1:text}}

Patient Email: {{*Email_es_:signer1:text}}

Jet ICU Representative Signature: {{Sig_es_:signer2:signature}}

Complete the following (below) only if the person signing this agreement is not the patient:

My signature below indicates that, at the time of service, the patient named above was physically incapable of signing.

I am signing on behalf of the patient to agree to the terms of this services agreement, designate an authorized representative, authorize release of health information, assign benefits, and to accept financial responsibility on behalf of

the patient.

By signing below, I acknowledge that I am one of the following: (1) parent of a minor patient; (2) the patient's legal guardian; (3) the patient's next of kin (when patient is deceased); (4) the patient's court appointed representative; (5) health care power of attorney; (6) executor of the estate; (7) a relative or other person who receives government benefits on the patient's behalf; (8)

a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; (9) a representative of an agency or institution that did not furnish the serves for which payment is claimed; (10) the provider of services in this matter; (11) health care professional with knowledge of the patient's condition; (12) the treating health care professional;
(13) the authorized billing agent of the services provider in this matter.

Complete the following only if the person signing the Patient Services Agreement is not the patient:	
Representative's Signature:	{{OSig_es_:signer1:optsignature}}
Representative's Printed Name:	{{Name_es_:signer1:text}}
Representative's Address:	{{Address2_es_:signer1:text}}
Representative's Relationship to Patient or Legal Authority:	{{relationship_es_:signer1:text}}
My signature is not an acceptance of financial responsibility for the services rendered.	

Reason patient unable to sign: *The circumstances that make it impractical for the patient to sign include (1) Patient is a child/minor; (2) Patient unconscious/nonresponsive; (3) Patient suffered injuries to both arms and hands; (4) Patient is sedated; (5) Other (please explain): {{reason_es_:signer1:text}}*

{{[]}} Check this box if the representative signer is the patient's: (1) legal guardian; (2) health care power of attorney; (3) court appointed representative.

Witness Signature:	
Witness Printed Name:	