OPT-OUT FORM

COMPLETE THIS FORM ONLY AT THE OFFICE OF COMBINE WATER SUPPLY CORP (410 FM 1389 SOUTH, COMBINE, TX 75159)

Name:____

Address:____

City/State/Zip Code:___________________________________

Combine Water Supply Corp. Member Number:________________

The undersigned member of Combine Water Supply Corporation (herein referred to as "Combine WSC") hereby notifies Combine WSC and CareFlite that he/she exercises the right to opt-out of the payment of the $1.00 monthly fee for a CareFlite membership and thereby elects to opt-out of the CareFlite membership program.

The undersigned acknowledges that if he/she completes this opt-out form at the office of Combine WSC on or before December 18, 2015, that the undersigned and the members of the household of the undersigned will not participate in the CareFlite membership program that will start January 1, 2016.

The undersigned acknowledges that he/she may opt-out of the CareFlite membership program after December 18, 2015 by completing this form at the office of Combine WSC. Such opt-out will be effective as of the first day of a month that begins ten (10) days after Combine WSC receives this completed notice of the opt-out from the member.

As a result of opting-out of the CareFlite membership program, I acknowledge that no one in my household will receive the benefits of the CareFlite membership program which protects families from out-of-pocket costs for CareFlite's air and ground ambulance services and related emergency and non-emergency services.

____ Date Signed:______________________

Signature of Combine WSC Member

____

(Printed Name of Member)

____ Date Signed:______________________

Signature of Combine Water Supply Corporation Employee Witnessing Signature of Combine Water Supply Member Above

____

(Printed Name of Employee)

For CWSC use only:

$1.00 CareFlite Membership Fee removed from the account of the member named above effective the 1st

day of____________________, 2016.