

Membership Application For Republic Ambulance "Care Plan"

(Please Print)

Name: Last _____ First _____ Middle _____

Address: _____ Fire ID# _____ Home Phone _____

Date of Birth: _____ Medicare Number: _____ Social Security No.: _____

Single: Married Widowed:

Retired From: _____ Employer: _____

Insurance / Supplemental Insurance

Company Name: _____ Policy Number: _____

City: _____ State: _____ Zip Code: _____

DEPENDENTS:

Name: Last _____ First _____ Middle _____

Dependent Social Security or Medicare # _____ Birth Date _____

Name: Last _____ First _____ Middle _____

Dependent Social Security or Medicare # _____ Birth Date _____

Name: Last _____ First _____ Middle _____

Dependent Social Security or Medicare # _____ Birth Date _____

Name: Last _____ First _____ Middle _____

Dependent Social Security or Medicare # _____ Birth Date _____

I understand that in order for my membership in the Republic Township Ambulance "Care Plan" to be effective, I must use the services of the Republic Township Ambulance. I understand that the membership fee per year provides emergency medical service plus ambulance transportation at no additional out-of-pocket cost to me, provided it is medically necessary. I authorize Republic Township to bill my insurance carrier or third party payer for any customary charges associated with this service. Republic Township agrees to accept those payments in full. I further understand that local services other than to and from a hospital are rendered at \$235 per trip and \$8 per loaded mile. Republic Township will also charge for materials used, if any. I also understand that physician authorization is required for all routine medical transfers to and from hospitals and that emergency calls have first priority.

I understand that this membership is nonrefundable and nontransferable. My membership will start April 1, 2008, and will expire March 31, 2009. The fee for this plan is **\$15 for one person, \$30 for a couple, and \$40 for a family.**

I affirm that I have read and agree to the terms of this membership as described above.

Signature _____ Date: _____ / _____ / _____
Month Day Year

MEMBERSHIP WILL NOT BECOME EFFECTIVE WITHOUT YOUR SIGNATURE ON THIS APPLICATION

This is not an insurance program and does not reduce the obligations of any third party payer. Republic Township retains the right to bill Medicare, Medicaid and private insurance companies for services provided. This program is subject to changes to Medicare reimbursement and may not be changed or terminated without notice.