UNINSURED PARTICIPANT

Last Name First Name Middle

Mailing Address Physical Address City State Zip Code

Single Married Widowed

Social Security Number

DEPENDANTS	DATE-OF-BIRTH	DEPENDANT'S SOCIAL SECURITY OR MEDICARE NUMBER
1		
2		
3		
4		

Membership will not become effective without your signature on the bottom of 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 change in Medicare reimbursement and may not be changed or terminated without notice.

REPUBLIC TOWNSHIP AMBULANCE "CARE PLAN" MEMBERSHIP CONTRACT FOR UNINSURED RESIDENTS OR RESIDENTS WITHOUT AMBULANCE COVERAGE UNDER INSURANCE CARRIERS

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 **($15.00 for one person, $30.00 for a couple, $40.00 for a family)** enrolls me in the "Care Plan" pool as an *uninsured participant*. I understand that if I use the services of the Republic Township Ambulance, the "Care Plan" will pay the first $250.00 of the ambulance bill, this amount being based on this year's highest verified insured member's deductible, and I will be responsible for, **AND AGREE TO PAY**, the remainder of the bill. I further understand that local services are rendered at $235.00 per trip and $8.00 per loaded mile. Republic Township will also charge for materials used, if any.

I understand that this membership is nonrefundable and nontransferable. My membership will start April 1, 2008 and will expire on March 31, 2009.

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

Signature Date