Date Received

Check #

A SERVICE OF THE BEDFORD FIRE DEPARTMENT CALL 817-952-2500

Ambulance Subscription Program Membership Application

COVERAGE PERIOD: January 1 through December 31- 2017

PLEASE PRINT (Complete in Full)

Last Name_____ First_____ Middle Initial_____

Mailing Address_____ Apt. No._____

City_____ State_____ Zip_____

Telephone Number_____ Social Security #_____ Birth date_____

Employer_____Address_____

List spouse, children under 25, and other dependents listed on your tax return and regularly living at home. (First name, middle initial, last name if different than member)

Name	Date of Birth	Social Security #	Relationship

Primary Member Insurance Information

Please provide copies of both sides of insurance cards.

It is not necessary to fill out the insurance information if copies of insurance cards are provided.

MEDICARE INFORMATION

Medicare Number: _____

Name (on Medicare Card) Medicare Number

Medicare Supplement Health Insurance

Supplement Insurance Name: _____ Supplement Group Number: _____

Supplement ID Number: _____

Supplement Claims Mailing Address: _____ City: _____

State: _____ Zip: _____ Claims mailing address is usually on the back of the insurance card.

COMMERCIAL INSURANCE INFORMATION

Primary Health Insurance Company Name: _____ Group Number: _____

Primary Health Insurance ID Number: _____

Claims Mailing Address: _____City: _____

State: _____ Zip: _____ Claims mailing address is usually on the back of the insurance card.

Spouse Insurance Information

Medicare Number: _____

Name (on Medicare Card) Medicare Number

Medicare Supplement Health Insurance

Supplement Insurance Name: _____ Supplement Group Number: _____

Supplement ID Number: _____

Supplement Claims Mailing Address: _____ City: _____ State: _____ Zip: _____ Claims mailing address is usually on the back of the insurance card.

-OVER-

COMMERCIAL INSURANCE INFORMATION- List other dependents insurance here

Name of Dependent(s) listed on this insurance: _____

Primary Health Insurance Company Name: _____ Group Number: _____

Primary Health Insurance ID Number: _____

Claims Mailing Address: _____City: _____

State: _____ Zip: _____ Claims mailing address is usually on the back of the insurance card.

Payment Options:

Option 1 A check or money order in the amount of $ 60.00 must accompany this application

I am enclosing a check or money order for $60.00 to become a member. (Non-refundable)

Option 2 Payment by credit card (in person at 1816 Bedford Rd or over the phone).

Card Type (Circle Credit Card): **Visa** **Master Card**

Make check or money order payable to: **Bedford Fire Department, 1816 Bedford Road, Bedford, Texas 76021**

AGREEMENT – THIS IS NOT AN APPLICATION FOR AN INSURANCE POLICY

I hereby apply for membership with the Bedford Fire Department Ambulance Subscription Service. I understand that the enclosed annual fee of $60.00 will cover myself, spouse, and unmarried children under 25 years of age and any other qualified dependents as determined by the IRS and who may live at this address. I understand that through this membership the Bedford Fire Department will provide emergency ambulance service within the City of Bedford through the Bedford Fire Department. I also understand and give my permission for the Bedford Fire Department to bill my insurance and to obtain benefits, which are entitled through my insurance carriers. **This membership will cover the portion unreimbursed by my medical coverage for services rendered by the Bedford Fire Department during the time of my membership. If a person does not have health care insurance, this program covers emergency medical services delivered prior to hospital arrival.**

I authorize the release of medical information for the purpose of billing my insurance. I understand that should I or a family member receive payment from insurance or any other medical provider for services rendered by the Bedford Fire Department, the payment will be immediately forwarded to the Bedford Fire Department to the extent necessary to satisfy any balance due.

I do understand that **Medicaid Recipients are not eligible** for the Bedford Fire Department memberships. I understand and agree that the EMS Service to be provided under this agreement is for a governmental service and the liability of the city, its employees and officials is to be governed solely by the Texas Tort Claims Act, Chapter 101, Texas Government Code. This agreement does not constitute a waiver or modification of such laws.

I understand the Bedford Fire Department provides ambulance transportation in true emergencies cases only and not for transfer ambulance service. Violations of the terms of this agreement may result in immediate cancellation of my membership or other penalty. I also understand that this membership is non-refundable and non-transferable.

To The Insurance Company

I authorize a copy of this agreement to be used in lieu of the original on file at the Bedford Fire Department. The original may be furnished on request. I authorize payment of insurance benefits for ambulance service for myself or family members directly to the Bedford Fire Department according to our agreement and as itemized on the attached claims. I have paid the co-payment for ambulance services to be rendered and expect your usual and customary ambulance reimbursement on my behalf to be sent to the Bedford Fire Department.

IMPORTANT: Must be signed to be valid.

_____ _____

MEMBER'S SIGNATURE **SPOUSES SIGNATURE**

I have read the above and agree with the above I have read the above and agree with the above

For Additional Information call- (817) 952-2500