VALE AMBULANCE

MEMBERSHIP APPLICATION

Address:_____

Hm Phone#_____**Wk#**_____

Insurance Information

Primary Name_____Secondary Name_____

Policy #_____ GR#_____Policy#_____GR#_____

(For additional names please add to separate sheet)

All Household Members over 18 Must Sign this application

Signature:_____**Signature:**_____

Signature:_____**Signature:**_____

This allows Vale Ambulance to bill your insurance and gives consent to treatment as well as agreeing to the terms listed below:

Membership Terms of Agreement

I agree that the Vale Ambulance Membership Program includes myself and all eligible persons who live at my address. I understand that the fee provides coverage only in the Vale Ambulance District and that coverage extends for one year after I pay my dues. Non-emergency service is covered only when medically necessary. **You must have insurance in force to be covered by this membership.** I understand that this is not insurance but will cover me above what is allowed by my insurance coverage or medical benefits. I further authorize the release of medical information necessary for the purpose of billing. Should I or any member of my household receive any benefits payable for the Ambulance Service we will immediately forward them to the Vale Ambulance Service. Vale Ambulance Membership is not solicited from persons who receive welfare medical benefits and such membership constitutes a voluntary contribution. Any violations of the terms of this contract may result in immediate cancellation. **Payment of $50.00 must accompany this application.** If paying by check please make check payable to **Vale Ambulance Services.**

House Members

Last Name_____First Name_____DOB____/____/_____

SSN____/____/_____

Last Name_____First Name_____DOB____/____/_____

SSN____/____/_____

Last Name_____First Name_____DOB____/____/_____

SSN____/____/_____

Last Name_____First Name_____DOB____/____/_____

SSN____/____/_____

Household members include those who are immediate family members living at the same address or family members living in assisted care facilities within the Vale Ambulance District.

To the Insurance Carrier: Any copy of this may be used in lieu of the original on file at the Vale Ambulance Office. I authorize payment of insurance benefits for services for above named persons. My membership fee will cover any deductible or co-pay.

Your usual payment on my behalf is to be sent to the Vale Ambulance Service at 252 B St W Vale Or 97918

Any questions regarding Terms may be answered at 473-3796. Ambulance Membership is not required for service.

This membership is non-refundable and non-transferable. Gift certificates are available.