LOWER ALLEN TOWNSHIP EMERGENCY MEDICAL SERVICES
2020 ANNUAL SUBSCRIPTION REQUEST

PLEASE NOTE:

If you do not have health care coverage or your health care coverage does not cover ambulance transportation, or you are a Medicaid recipient, you are not eligible to become a subscriber.

INDIVIDUAL	HOUSEHOLD	DONATION	TOTAL
$75.00	**$95.00**		

THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY

Name _____

Address _____

_____ Phone _____

_____

_____

SPECIAL NEEDS

Would any household subscribers need special assistance, should an emergency evacuation become necessary? You MUST update any special needs information each year.

❍ Yes ❍ No *(non-ambulatory, deafness, blindness, etc.)* – If so, please list subscriber's name and their special needs:

_____

SIGNATURE ACKNOWLEDGEMENT

I apply for participation as a subscriber in the subscription program of Lower Allen Township. I agree to the terms and conditions of the subscription described above. I verify that I am not a Medicaid recipient or an individual who does not have health care coverage or an individual whose health insurance does not cover ambulance transportation. I request payment of authorized Medicare or any other insurance benefits be made on my behalf to Lower Allen Township for any ambulance services provided to me by Lower Allen Township now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Lower Allen Township. I understand that I may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Lower Allen Township any payments that I receive directly from my insurance or any source whatsoever for the services provided to me and I assign all right to such payments to Lower Allen Township.

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this subscription program and I hereby apply to be a subscriber of Lower Allen Township.

Signature of Primary Subscriber _____ Date _____
(also authorized to sign for minor household members)

Please complete and sign the subscription application, and return, along with check or money order. The subscription application will be returned to you if it is not completed in its entirety.

Make checks payable to Lower Allen Township EMS.
2233 Gettysburg Road, Camp Hill, PA 17011
If you have any questions regarding ambulance service phone the EMS administration office - 717-975-7575.

THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED

If you lose insurance coverage or your insurance company changes, you MUST notify Lower Allen Township EMS.

All subscriptions are subject to acceptance by Lower Allen Township and may be cancelled or revoked at Lower Allen Township's sole discretion.

Your subscription will immediately terminate when your home address changes to an area outside of Lower Allen Township. Lower Allen EMS will not be responsible for the reimbursement of any other ambulance service.

Subscription Expires December 31, 2020

PLEASE COMPLETE THE APPROPRIATE SECTION OR SECTIONS. HEALTH INSURANCE INFORMATION IS NEEDED FOR EACH INDIVIDUAL LIVING IN YOUR HOME.

COMPLETE THIS SECTION IF MEDICARE IS YOUR PRIMARY INSURANCE

MEDICARE ID#_____ INSURED'S NAME_____

MEDICARE ID#_____ INSURED'S NAME_____

IF YOU HAVE SUPPLEMENTAL INSURANCE THAT SECTION OF THE FORM WILL ALSO NEED COMPLETED

COMPLETE THIS SECTION WITH YOUR SUPPLEMENTAL INSURANCE

INSURANCE COMPANY NAME_____ GROUP#_____

ID#_____ INSURED'S NAME_____

***BE SURE TO INCLUDE THE ALPHA PREFIX

INSURANCE COMPANY NAME_____ GROUP#_____

ID#_____ INSURED'S NAME_____

***BE SURE TO INCLUDE THE ALPHA PREFIX

COMPLETE THIS SECTION IF YOUR HEALTH INSURANCE IS A MEDICARE ADVANTAGE PLAN

(ADVANTRA, CBC SENIOR BLUE, AETNA GOLDEN MEDICARE, HIGHMARK FREEDOM BLUE, HUMANA ETC.)

INSURANCE COMPANY NAME_____ GROUP#_____

ID#_____ INSURED'S NAME_____

***BE SURE TO INCLUDE THE ALPHA PREFIX

INSURANCE COMPANY NAME_____ GROUP#_____

ID#_____ INSURED'S NAME_____

***BE SURE TO INCLUDE THE ALPHA PREFIX

COMPLETE THIS SECTION IF YOUR HEALTH INSURANCE IS WITH A COMMERCIAL CARRIER

(CAPITAL BLUE CROSS, HIGHMARK, AETNA ETC.)

INSURANCE COMPANY NAME_____ GROUP#_____

ID#_____ INSURED'S NAME_____

***BE SURE TO INCLUDE THE ALPHA PREFIX

****LIST THE NAMES OF FAMILY MEMBERS LIVING IN YOUR HOME THAT ARE COVERED UNDER THE ABOVE HEALTH INSURANCE POLICY

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*****IF THERE ARE FAMILY MEMBERS LIVING IN YOUR HOME WITH DIFFERENT HEALTH INSURANCE, PLEASE LIST THAT INFORMATION BELOW

INSURANCE COMPANY NAME_____ GROUP#_____

ID#_____ INSURED'S NAME _____

***BE SURE TO INCLUDE THE ALPHA PREFIX

****LIST THE NAMES OF FAMILY MEMBERS LIVING IN YOUR HOME THAT ARE COVERED UNDER THE ABOVE HEALTH INSURANCE POLICY

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