EBENSBURG AREA AMBULANCE ASSOCIATION SUBSCRIPTION

List All Eligible Family Members

Name	Date of Birth	Name	Date of Birth
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Expires: February 28, 2019 (continue on back)

Telephone: _____

I authorize the payment of insurance benefits directly to Ebensburg Area Ambulance Assoc. for services rendered to me or a member of my family by that association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its Agents or other insurance companies any information needed to determine these benefits or those payable for related services. A copy of this authorization shall be as valid as the original. I agree that any reimbursement by insurance company for services rendered is payable to Ebensburg Area Ambulance Association.

_____

Signature of Policy Holder

(Subscription Invalid Without Signature)

*****CHECK ONE*****

❒ **Family** **$75.00** ❒ **Individual** **$55.00**

RETURN THIS CARD

Ebensburg Area Ambulance Association SUBSCRIPTION

Expires: February 28, 2019

Date Paid: _____

Check #_____

Subscription covers EMERGENCY transport from the service area to any hospital within a 30 mile radius. Trips beyond 30 miles will be charged per loaded mile. NON-EMERGENCY transport requires written authorization from treating physician. If insurance does not cover transport, the patient may be responsible for expenses.

ANNUAL MEETING

Second Monday of March

KEEP THIS PART AS YOUR RECEIPT