TRI-COUNTY EMERGENCY FIREMED MEDICAL

APPLICATION FOR MEMBERSHIP

$65

Your #1 Lifesaving Team

FireMed is the Lifesaving Emergency Ambulance Membership Program
of the Dinuba, Kingsburg, Sanger and Selma Fire Departments.

420 E. Tulare St.
Dinuba, CA 93618

ENROLLMENT LIMITED TO SEPTEMBER AND OCTOBER

PLEASE PRINT *(Fill out completely)*

Date _____

LAST NAME _____ Telephone _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Mailing Address (if different than above) _____

City _____ State _____ Zip _____

Membership (check one): New ◯ Renewal ◯

Household Members **Last Name** (if different from Head of Household)	**First Name**	**Middle Initial**	**Male/ Female**	**Relationship to Head of Household**	**Date of Birth Mo.**	**Day**	**Yr.**
Head of Household							
Spouse or Dependent							
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							

Please answer the following insurance questions. CHECK APPROPRIATE BOXES:	YES	NO
Does anyone on your FireMed membership have Medicare?	◯	◯
Does anyone on your FireMed membership have medical insurance in addition to, or in place of Medicare?	◯	◉
Does anyone on your FireMed membership have Medi-Cal?	◯	◯

Where did you hear about FireMed? In the mail ☐ Newspaper ☐ Radio ☐ Other _____

As discussed in the terms of agreement, FireMed will bill your insurance and accept whatever it pays as payment-in-full. You will owe nothing.

Please fill this form out completely, sign the signature form below (all appropriate family members), and return this form along with the fee by October 31st.

FIREMED AGREEMENT

(Please read information carefully before signing below.)

I hereby apply for membership in FireMed for myself and eligible* family members who live at my address. I understand the enclosed fee provides emergency ambulance care and transportation **within the Tri-County FireMed service areas**, and non-emergency ambulance service as noted below. If an *additional* transport is required between health facilities, another ambulance company may be involved and this *additional* transport may not be covered by FireMed. Coverage begins upon acceptance of the application and extends to October 31 of the following year. Non-emergency ambulance service to hospitals and 24 hour emergency medical receiving facilities, are covered **when medically necessary by your insurance with prior written authorization by a physician.** I understand that FireMed is **not** insurance but will provide ambulance service through the Tri-County FireMed and will bill whatever insurance or medical benefits I may have and is entitled to **primary** and **secondary** insurance payment. FireMed is in excess of any insurance or medical benefits which I may have. **I further authorize the release of medical information for the purpose of ambulance insurance billing only.** Should I or a family member receive payment from insurance or other medical benefits provider for ambulance service rendered by the Tri-County FireMed, **I will immediately forward such payment to the appropriate transporting agency.** FireMed membership may be considered for welfare recipients for services that may **not** be covered under their plan. I understand that violations of the terms of this agreement may result in immediate cancellation. **This membership is non-refundable and non-transferable.**

*DEFINITION OF FAMILY

FireMed membership covers immediate family members living in the same household. The member, spouse, unmarried children under age 25 and other persons **listed as legal dependents for income tax purposes** are covered. Others **not** included in this definition are required to obtain their own **separate** membership.

TO THE INSURANCE CARRIER

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

Head of Household _____ (Signature)

Spouse _____ (Signature)

Dependent _____ (Signature)

Dependent _____ (Signature)

A check, money order or cash must accompany this application. Please make check payable to FireMed.

I have enclosed payment by: (◯) Money Order (◯) Cash (◯) Check

YOUR CANCELLED CHECK OR MONEY ORDER RECEIPT IS PROOF OF MEMBERSHIP