

Last Name	First Name	MI	Relationship	Date of Birth	Social Security #

INSURANCE INFORMATION

Circle all appropriate: Medical Insurance Auto Insurance Medicare

Primary Medical Ins Co: _____

Policy or ID # _____ Group: _____

Address: _____

Phone: _____

Secondary Medical Ins Co: _____

Policy or ID # _____ Group: _____

Address: _____

Phone: _____

Auto Ins Co: _____

Policy or ID # _____ Group: _____

Address: _____

Phone: _____

AGREEMENT

I represent that the foregoing information is true and accurate. I have read and agree with the terms of the Ambulance Membership Program Agreement. I further understand that my insurance provider(s) will be billed for payment, and that any co-payment required under my insurance policy(ies) not paid by my insurance provider(s) will be paid by the Louisville Fire Protection District Ambulance Membership Program in accordance with the terms of the Program in full satisfaction of Louisville Fire Protection District's emergency medical/ambulance transport charges.

To my insurance carrier(s) or other provider of medical benefits:

- I authorize a copy of this Enrollment Form and Agreement to be used in lieu of the original on file at the Louisville Fire Protection District's office.
- I authorize payment of benefits be made directly to the Louisville Fire Protection District for emergency medical/ambulance transport services for eligible family members or myself.
- I authorize and direct reimbursement for emergency medical/ambulance services pursuant to my policy(ies) to be sent directly to the Louisville Fire Protection District.

Signature

Date

(Please keep copy for your records.)

I heard about this program from:

- Friend/Family
- Louisville Fire Protection District Website
- Other _____