



A SERVICE OF THE BEDFORD FIRE DEPARTMENT CALL 817-952-2500

**Ambulance Subscription Program  
Membership Application**

Date Received  
Check #

**COVERAGE PERIOD: January 1 through December 31- 2015**

PLEASE PRINT (Complete in Full)

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_  
Mailing Address \_\_\_\_\_ Apt. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_

List spouse, children under 25, and other dependents listed on your tax return and regularly living at home. (First name, middle initial, last name if different than member)

Name	Date of Birth	Social Security #	Relationship

**Primary Member Insurance Information** Please provide copies of both sides of insurance cards. **It is not necessary to fill out the insurance information if copies of insurance cards are provided.**

**MEDICARE INFORMATION**

Medicare Number: \_\_\_\_\_  
Name (on Medicare Card) Medicare Number  
Medicare Supplement Health Insurance  
Supplement Insurance Name: \_\_\_\_\_ Supplement Group Number: \_\_\_\_\_  
Supplement ID Number: \_\_\_\_\_  
Supplement Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claims mailing address is usually on the back of the insurance card.

**COMMERCIAL INSURANCE INFORMATION**

Primary Health Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Primary Health Insurance ID Number: \_\_\_\_\_  
Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claims mailing address is usually on the back of the insurance card.

**Spouse Insurance Information**

Medicare Number: \_\_\_\_\_  
Name (on Medicare Card) Medicare Number  
Medicare Supplement Health Insurance  
Supplement Insurance Name: \_\_\_\_\_ Supplement Group Number: \_\_\_\_\_  
Supplement ID Number: \_\_\_\_\_  
Supplement Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Claims mailing address is usually on the back of the insurance card.

## Other Dependent Insurance Information

Dependant Health Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Dependent Health Insurance ID Number: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claims mailing address is usually on the back of the insurance card.

### **Payment Options:**

**Option 1** A check or money order in the amount of \$ 60.00 must accompany this application

I am enclosing a check or money order for \$60.00 to become a member. (Non-refundable)

**Option 2** Payment by credit card (in person at 1816 Bedford Rd or over the phone).

Card Type (Circle Credit Card):     **Visa**             **Master Card**

Make check or money order payable to: **Bedford Fire Department, 1816 Bedford Road, Bedford, Texas 76021**

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### **AGREEMENT – THIS IS NOT AN APPLICATION FOR AN INSURANCE POLICY**

I hereby apply for membership with the Bedford Fire Department Ambulance Subscription Service. I understand that the enclosed annual fee of \$60.00 will cover myself, spouse, and unmarried children under 25 years of age and any other qualified dependents as determined by the IRS and who may live at this address. I understand that through this membership the Bedford Fire Department will provide emergency ambulance service within the City of Bedford through the Bedford Fire Department. I also understand and give my permission for the Bedford Fire Department to bill my insurance and to obtain benefits, which are entitled through my insurance carriers. **This membership will cover the portion unreimbursed by my medical coverage for services rendered by the Bedford Fire Department during the time of my membership. If a person does not have health care insurance, this program covers emergency medical services delivered prior to hospital arrival.**

**I authorize the release of medical information for the purpose of billing my insurance. I understand that should I or a family member receive payment from insurance or any other medical provider for services rendered by the Bedford Fire Department, the payment will be immediately forwarded to the Bedford Fire Department to the extent necessary to satisfy any balance due.**

I do understand that **Medicaid Recipients are not eligible** for the Bedford Fire Department memberships. I understand and agree that the EMS Service to be provided under this agreement is for a governmental service and the liability of the city, its employees and officials is to be governed solely by the Texas Tort Claims Act, Chapter 101, Texas Government Code. This agreement does not constitute a waiver or modification of such laws.

I understand the Bedford Fire Department provides ambulance transportation in true emergencies cases only and not for transfer ambulance service. Violations of the terms of this agreement may result in immediate cancellation of my membership or other penalty. I also understand that this membership is non-refundable and non-transferable.

### To The Insurance Company

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

**IMPORTANT: Must be signed to be valid.**

\_\_\_\_\_  
**MEMBER'S SIGNATURE**

I have read the above and agree with the above

\_\_\_\_\_  
**SPOUSES SIGNATURE**

I have read the above and agree with the above

**For Additional Information Call 817-952-2500**