Care Plan Membership Service Agreement

Rockford AMBULANCE
A NATIONALLY ACCREDITED AMBULANCE SERVICE

Your initial membership payment covers everyone in your household from the time Rockford Ambulance receives the signed contract and full payment of $60 and continues until **September 30**. All members must be on record with Rockford Ambulance to receive benefits.

Membership covers emergency transports to the hospital at no out-of-pocket expense during the contract period if you have insurance.

If you do not have insurance, your membership entitles you to a 50% discount on your total bill. You understand that you are responsible for paying the balance.

You understand that the patient is responsible for the payment of services, and that because you are a Care Plan Member, Rockford Ambulance will accept your active insurance company or medical benefit provider's reimbursement as payment in full. Your policy must cover ambulance services. You agree to cooperate with the claim submission to your medical benefit providers and to provide any correspondence regarding this claim to Rockford Ambulance if requested. You further agree to submit any insurance reimbursement you may receive for Rockford Ambulance and its affiliates directly to Rockford Ambulance. Failure to fully cooperate with Rockford Ambulance and abide by these terms will result in termination of your membership and make you responsible for any unpaid expenses.

Membership in Rockford Ambulance Care Plan is non-transferable and non-refundable. For federal tax purposes, the membership fee is not deductible as a charitable contribution, but may be eligible for deduction as an itemized medical expense. Rockford Ambulance does not solicit from persons who receive welfare medical benefits, and membership constitutes a voluntary contribution only. This is not an application for an insurance policy. You request that payment of authorized Medicare/insurance benefits be made on your behalf to Rockford Ambulance for services provided by Rockford Ambulance. You authorize any holder of medical information about you to be released to the health care finance administration, its agents and carriers as well as Rockford Ambulance that may be necessary to determine benefits payable for services by Rockford Ambulance. You agree you will sign any HIPAA authorization required. For questions call 616-866-0724

Care Plan Membership Application

Covered Members Living in the Household

Detach & Remit with Payment

Last Name	First Name	Birth Date	Social Security No.

Home Address of Members | City | State | Zip

Township | Home Phone | Cell Phone

Payment Information

☐ Check or money order for $60 **payable to Rockford Ambulance** is enclosed.

☐ Please charge my credit card for the $60. ☐ Discover ☐ Mastercard ☐ Visa

Card No. _____ Expiration Date _____

3 Digit CSV Code _____ Billing Zip Code _____

Please sign below acknowledging your acceptance of the terms of the membership agreement.

Signature: _____ **Date:** _____

Spouse's Signature: _____ **Date:** _____

For Emergencies

Call 911

Save time & paper and enroll online!

www.RockfordAmbulance.com

or