

Membership Application

IMPORTANT NOTE: Medicaid recipients ARE NOT ELIGIBLE.

I hereby apply for membership with my local emergency medical service program. I understand that the enclosed annual fee will cover me, my spouse and my dependent children living in my residence who are under age 21 or 25 if in college. I understand that through this membership, East Texas Medical Center EMS will provide emergency ambulance service within the service area.

EMS standard emergency fees and I am therefore responsible for payment of 50 percent of the total charges.

I understand that violations of the terms of this agreement may result in immediate cancellation of my membership or other penalty.

I understand that if I have no health insurance or third-party health insurance, my membership entitles me to 50 percent coverage of billed ETMC

FOR OFFICE USE ONLY

Date Received	Check Number	Amount

Head of household		M	F	Spouse		M	F
LAST NAME	FIRST NAME			LAST NAME	FIRST NAME		
DATE OF BIRTH	PHONE NO.			DATE OF BIRTH	PHONE NO.		
EMAIL ADDRESS				DATE OF BIRTH			
SOCIAL SECURITY NUMBER	MEDICARE NO.			SOCIAL SECURITY NUMBER	MEDICARE NO.		
MAILING ADDRESS & APT. NO.				CITY, STATE, ZIP CODE		COUNTY	

Household members' information (If additional space is needed, please use separate sheet.)

M <input type="checkbox"/> LAST NAME F <input type="checkbox"/>	FIRST NAME & MIDDLE INITIAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH
M <input type="checkbox"/> LAST NAME F <input type="checkbox"/>	FIRST NAME & MIDDLE INITIAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH
M <input type="checkbox"/> LAST NAME F <input type="checkbox"/>	FIRST NAME & MIDDLE INITIAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH

Health insurance information (other than Medicare)

(If you don't have health insurance, skip to payment section.)

INSURANCE COMPANY	POLICY OR ID NUMBER	GROUP NUMBER
INSURANCE COMPANY ADDRESS	CITY, STATE, ZIP CODE	IS FAMILY COVERED? YES <input type="checkbox"/> NO <input type="checkbox"/> IS SPOUSE COVERED? YES <input type="checkbox"/> NO <input type="checkbox"/>

Payment information (IMPORTANT: Must be signed to be valid.)

- * Check the annual membership fee that applies to you:
 - \$60 (new membership with health insurance)
 - \$68 (new or renewed membership without health insurance)
 - Personal Check or Money Order Please make check or money order payable to **East Texas Medical Center EMS.**
 - VISA MasterCard American Express Discover

Name on Credit Card _____ Card No. _____ Exp. Date _____

I authorize a payment of \$5 a month on the following water/billing system (available only to applicants with health insurance):

Arp, Athens, Bullard, Craft Turney, Hideaway Lake, Mart, Murchison, RPM Water Supply, Rusk, Rusk Rural Water, Troup and Tyler.

NO PAYMENT ENCLOSED. I currently reside within the city of Mineola, where membership is automatic, but I am sending my information for EMS to have on file.

I authorize any holder of medical information or documentation about me or any person covered under my East Texas Medical Center Emergency Medical Service (ETMC EMS) membership to release to ETMC EMS and the Centers for Medicare and Medicaid Services and its agents and carriers any information or documentation needed to determine benefits payable for services provided by any and all of my insurers and any third-party agencies. I further authorize my insurers and any third-party agencies to pay directly to ETMC EMS whatever benefits or payments may be available for services rendered to me or my dependents by ETMC EMS, now or in the future.

I agree to provide ETMC EMS all information necessary to file a claim for payment under my insurance policy, plan or program or from any third-party payor.

Membership is nontransferable and nonrefundable and may be canceled upon member's noncompliance herewith. Enrollment is available year-round, and the enrollment fee will be prorated for the membership year, October 1 to September 30.

Member's Signature (Required for membership)

Date

MUST LIVE IN THE ETMC EMS SERVICE AREA FOR MEMBERSHIP

I acknowledge that I am responsible for payment for the ambulance services provided for me. Please sign after reading contract terms on reverse side.

For immediate protection, enroll online at etmc.org/ems.membership

Complete membership application and mail it to address shown — no postage required!