FAMILY MEMBERSHIPS - CONSISTS OF A HUSBAND AND WIFE WITH CHILDREN UNDER 18 YEARS OF AGE. FAMILY MEMBERSHIPS ALSO INCLUDES CHILDREN THAT ARE FULL TIME STUDENTS BETWEEN 18 AND 24 YEARS OF AGE THAT ARE STILL ON THEIR PARENTS HEALTH INSURANCE.

IF YOU WOULD NO LONGER LIKE US TO SEND THIS INFORMATION TO YOU - PLEASE CHECK THE BOX BELOW AND RETURN THIS ENTIRE FORM. ☐

This subscription entitles holder unlimited Emergency Medical Service until December 31, 2018, subject to terms and conditions which are available upon request.

For additional information call:

724-224-1499

Thank You For Your Support

Sign and Return This Completed Form with Payment

Please list all family members residing in your home. Please print all names.

_____ _____

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_____ _____

Telephone Number: ( ) -_____ -_____

Authorization

I understand that I am financially responsible for the services provided to me or my family members by this health service provider supplier regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider or supplie authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medic Services and its carriers and agents, as well as to this health provider or supplier and their billing agents, any information or documentat needed to determine these benefits payable for any services provided to me by the health service provider, both now or in the future. A c of this form is as valid as the original. I also agree to immediately remit to this health service provider any payments that receive dire from any source for the services provided to me, now or in the future.

Signature: X _____ Date: _____

Head of Household