ENROLLMENT FORM

Adams County Ambulance Membership Program

Please check the type of membership requested

☐ *$***35 Individual** (covers only the individual signing this Enrollment Form)

☐ ***$60 Couple Membership*** (covers the individual signing this enrollment form and spouse living at your residence)

☐ ***$90 Family Membership*** (covers the individual signing this enrollment form and all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at your residence)

☐ **$50 Senior Couple Membership** (covers the individual signing this enrollment form, who must be 55 years or older, and spouse living at your residence)

☐ **$75 Senior Family Membership** (covers the individual signing this enrollment form, who must be 55 years or older, and all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at your residence)

Ck # _____ Cash. _____ Exp. Date 12/31/2018 Membership #_____

Complete, sign and return enrollment form and agreement with payment to:
Adams County Fire Protection District, 8055 N. Washington Street, Denver, CO 80229
If you have any questions, please call 303-539-6800

Please Print:

_____

Last Name First MI Street Address Apt. #

_____

City State Zip Code Telephone Number

_____

Mailing Address (if different than above) City State Zip Code

List all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at your residence.

	Last Name	First Name	M.I.	Relationship	DOB	Social Security #
Member						
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						

Circle all appropriate**:** → **Medical Insurance** (specify below) **Auto Insurance** (specify below) **Medicare**

Name of Primary Medical Insurance Co._____

Address_____

Name of Supplemental Medical Insurance Co._____

Address_____

Name of Auto Insurance Co._____

Address_____

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 company(ies) will be billed for payment, and that any co-payment required under my insurance policy(ies) not paid by my insurance company(ies) will be paid by the Adams County Ambulance Membership Program in accordance with the terms of the Program in full satisfaction of Adams County 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 Adams County Fire Protection District's office.
- I authorize payment of benefits for emergency medical/ambulance transport services for myself or eligible family members directly to the Adams County Fire Protection District.
- I authorize and direct reimbursement for emergency medical/ambulance services pursuant to my policy(ies) to be sent directly to the Adams County Fire Protection District.

(*Please keep copy for you records)*

_____

Signature Date