

APPLICATION FOR MEMBERSHIP



ALBANY FIREMED
PO BOX 490
ALBANY, OR 97321
(541) 917-7710

Payment of \$50 by:

- CHECK
Check # _____
Please make check payable to
City of Albany.
- CASH
Additional tax-deductible
contribution:
 \$50 \$100 \$_____

For Office Use Only

Membership # _____

Date Received _____

Expires June 30

Name _____ Date of Birth _____

Address _____ Phone _____

City/State/Zip _____ Social Security No. _____

Street Address (if different than above) _____

City _____ State _____ Zip _____

List eligible family members to be covered by FireMed who you can claim as a federal tax deduction, or dependents living in nursing or adult foster care homes. Please list full name, including any last name that is different from the above member's name.

Spouse _____	Birth Date _____	SS# _____
Name _____	Birth Date _____	Relationship _____
Name _____	Birth Date _____	Relationship _____
Name _____	Birth Date _____	Relationship _____
Name _____	Birth Date _____	Relationship _____

IF CHILDREN HAVE A PRIMARY INSURANCE OTHER THAN MEMBER OR SPOUSE, PLEASE LIST ON SEPARATE SHEET.

MEDICAL INSURANCE INFORMATION

MEMBER - Primary Insurance

Address _____

GRP No. _____ ID No. _____

Secondary Insurance

Address _____

GRP No. _____ ID No. _____

Auto Insurance _____ COMPANY _____

SPOUSE - Primary Insurance

Address _____

GRP No. _____ ID No. _____

Secondary Insurance

Address _____

GRP No. _____ ID No. _____

AGENT NAME _____

I (we) have read the FireMed Agreement on the reverse side and agree to the terms and conditions listed. I authorize payment of insurance medical benefits for ambulance service directly to Albany Fire Department Ambulance. My signature on this application authorizes Albany Fire Department Ambulance to submit any claims or bill any health insurance plan of which I am a member. My signature below indicates that I have received a copy of the FireMed Agreement and Albany Fire Department Ambulance Patient Privacy Notice.

X _____ Member's Signature	X _____ Spouse's Signature
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PAYMENT MUST ACCOMPANY THIS APPLICATION

ALBANY FIREMED AGREEMENT

Please read this agreement carefully and sign the reverse side for validation of your membership. Hereafter, FireMed means the City of Albany, and this agreement is between the City of Albany and the FireMed member. Payment in full must accompany this application for a FireMed membership to be in effect.

I hereby apply to FireMed for membership for myself and listed eligible family members*. I understand the membership fee provides medically-necessary** pre-hospital care and ambulance transportation. New membership coverage commences 48 hours after receipt of the FireMed application and fee, and extends to midnight the evening of June 30. I understand that FireMed is not insurance, but provides prepaid coverage in excess of any health insurance or medical benefits I may have. I authorize FireMed to bill directly for ambulance service to any such insurance. I agree to assign to FireMed any claim I may have for medical insurance benefits as a result of any service provided by FireMed while I am a member. I authorize the release of medical information for the purpose of ambulance insurance billing only, including to participating agencies in the Oregon FireMed network. Should I or a family member receive payment from insurance or any other medical benefit provider for ambulance service provided by FireMed, I will immediately forward such payment directly to FireMed. Failure to do so may be grounds for cancellation of FireMed agreement. This membership is non-refundable and non-transferable. FireMed membership is not solicited from persons who receive medical welfare benefits, and any such memberships constitute a voluntary contribution only.

SERVICES PROVIDED AND SERVICE AREA BOUNDARIES

A FireMed membership provides emergency pre-hospital medical care and ambulance transportation. All emergency service must originate within the boundaries of the Albany Fire Department ambulance service areas. Emergency transportation will be to the nearest medically-appropriate hospital as determined by Medical Control physicians.

Specifically not covered is non-medically-necessary transportation where means other than an ambulance should be used; including private vehicle, taxi, or wheelchair and stretcher van services. Examples of such uncovered services may include transportation to and from doctors' offices or clinics, transportation from nursing homes for treatment normally provided in the nursing homes, or transport back home from a medical facility when patient condition does not warrant an ambulance.

MEMBER BENEFITS OUTSIDE ALBANY FIREMED SERVICE AREA

Member benefits are extended to areas outside the Albany FireMed service area, but within the state of Oregon. These benefits are limited to the terms of agreement in effect by each FireMed participating agency at the time benefits are used. Members who receive ambulance service from any other FireMed participating agency are eligible for benefits offered by that agency provided that: 1) member is responsible to notify transport agency that they are an Albany FireMed member, 2) the member hereby agrees to the terms of the participating agency's agreement. A current list of FireMed participating agencies is on file in the FireMed business office.

INSURANCE CARRIER INFORMATION

I authorize a copy of this Agreement to be used in lieu of the original on file by FireMed. I authorize and expect payment of usual and customary insurance benefits for ambulance service for myself or family members directly to FireMed, according to the FireMed agreement and as itemized on attached statements.

***DEFINITION OF FAMILY**

A FireMed membership covers the member, spouse, or persons listed as legal dependents for income tax purposes. **Others not included in this definition are required to obtain separate memberships.** A spouse or dependent living in a nursing home or residential care facility is covered if the care facility is within FireMed service area boundaries. New dependents during the term of a FireMed membership are automatically covered.

****DEFINITION OF MEDICAL NECESSITY**

Ambulance transportation is medically-necessary when the patient's condition is such that use of any other method of transportation is contraindicated. In other words, the patient could not be transported by any other means of transportation without endangering their health, whether or not such other transportation is actually available.