

APPLICATION FOR MEMBERSHIP

\$65

Your #1 Lifesaving Team

FireMed is the Lifesaving Emergency Ambulance Membership Program of the Dinuba, Kingsburg and Selma Fire Departments.

420 E. Tulare St. Dinuba, CA 93618

ENROLLMENT LIMITED TO SEPTEMBER AND OCTOBER

PLEASE PRINT (Fill out completely)				Date			
LAST NAME			Te	lephone			
Street Address				A	vpt. # _		
City			Sta	ateZ	<u></u>		
Mailing Address (if different than above)							
City			Sta	ateZ	<u>'ip</u>		
Membership (check one): New ☐ Renewal ☐			Ð				
Household Members Last Name (if different from Head of Household)	First Name	Middlæ ##bbiM Lemale		Relationship to Head of Household	Date of Birth Mo. Day Yr.		
Head of Household							
Spouse or Dependent							
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Does anyone on your FireMed membership have medical in Does anyone on your FireMed membership have Medi-Cal Where did you hear about FireMed? In the mail As discussed in the terms of agreement, For as payment.	l? spaper □ Ra	dio □ C	other	ce and accept whatev	ver it pa	ays	
Please fill this form out completely, sign t	lha aignatura						
and return this forn					embers	s),	
FIR	n along with	the fee by	Octob	er 31st.	embers	s),	
(Please read informal I hereby apply for membership in FireMed for myself and el provides emergency ambulance care and transportation wis service as noted below. If an additional transport is required this additional transport may not be covered by FireMed. Co of the following year. Non-emergency ambulance service when medically necessary by your insurance with prior ance but will provide ambulance service through the Tri-Cou is entitled to primary and secondary insurance payment. If further authorize the release of medical information for the ber receive payment from insurance or other medical bene immediately forward such payment to the appr opriate recipients for services that may not be covered under their	EMED AGRE ation carefully ligible* family n thin the Tri-Co d between head overage begins to hospitals and written author inty FireMed and FireMed is in each the purpose of fits provider for transporting plan. I unders	EMENT y before sinembers whounty Fireled the facilities and 24 hour prization by excess of an angency. Fitand that vistand the vistand that vistand the vistand that vistand the vistand that vistand the vistand that vistand th	igning ho live a Med sees, anothe emerge a physical hateverny insurate servicire Med iolations	below.) at my address. I unders rvice areas, and non-e er ambulance company of the application and e ency medical receiving sician. I understand that insurance or medical be- rance or medical benefit irrance billing only. Sho ce rendered by the Tri-C membership may be o	tand the mergen or may be extends facilities facilities facilities to which buld I or County F	e enclos cy amb e involve to Octo s, are-co may ha o I may a family ireMed	ulance ed and ber 31 overed t insur- ve and have. I mem- l, I will welfare
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() Money Order () Cash

YOUR CANCELLED CHECK OR MONEY ORDER RECEIPT IS PROOF OF MEMBERSHIP

() Check

I have enclosed payment by: