



## Sign and Return This Completed Form with Payment

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

---

---

---

Please complete, sign and return this page also.

Telephone Number: (    ) -    -   

### Authorization

I understand that I am financially responsible for the services provided to me by Lawn Fire Company Ambulance, referred to as "LFCA", regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to LFCA or its billing agent for any services provided to me by the Centers for Medicare and Medicaid Services and its carriers and agents, as well as LFCA and its billing agents, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by LFCA, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to LFCA any payments that I receive directly from any source for the services provided to me.

This subscription entitles holder unlimited Emergency Medical Service, and additional ancillary services, until December 31, 2011, subject to terms and conditions which are available upon request.

Lawn Fire Company Ambulance reserves the right to all available third party claims.

For additional information call

**717-964-2369** (Option 2)

**Thank You For Your Support**

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Head of Household