EMS Life Line

A SERVICE OF ODESSA FIRE RESCUE • Call 432-257-0502

FOR OFFICE USE ONLY
Utility Account #
Date Received
Check #

Membership Application (Beginning January 1, 2017)

PLEASE PRINT (Complete in Full)

Last Name _____ First _____ Middle Initial _____

Mailing Address _____ Apt. # _____

City _____ State _____ Zip _____

Telephone Number _____ *Social Security # XXX - XX - _____ Date of Birth _____

Employer _____ Address _____

*** Required information.** ***Please list the last four digits of your Social Security Number for verification purposes.***

List spouse, children under 26, and other dependents listed on your tax return and regularly living at home.

(First name, middle initial, last name if different than member:)

Name	Date of Birth	Social Security #	Relationship
		XXX - XX -	
		XXX - XX -	
		XXX - XX -	
		XXX - XX -	
		XXX - XX -	
		XXX - XX -	

Please give the last four (4) digits of your Social Security Number.

Member Insurance Information

Name		Medicaid	Medicare
Primary Ins. Co.	Address	Policy No.	Ins. SSN.
Supplemental Ins.	Address	Policy No.	Ins. SSN
Other Ins.	Address	Policy No.	Ins. SSN

Spouse Insurance Information

Name		Medicaid	Medicare
Primary Ins. Co.	Address	Policy No.	Ins. SSN.
Supplemental Ins.	Address	Policy No.	Ins. SSN
Other Ins.	Address	Policy No.	Ins. SSN

Other Dependent Insurance Information

Name		Medicaid	Medicare
Primary Ins. Co.	Address	Policy No.	Ins. SSN.
Supplemental Ins.	Address	Policy No.	Ins. SSN
Other Ins.	Address	Policy No.	Ins. SSN

Not valid unless signed on reverse side.

–OVER–

PAYMENT OPTIONS:

☐ **OPTION I**

I am enclosing a check or money order for $59.00 to renew my Lifeline membership for January 1, 2017–December 31, 2017.

☐ **OPTION II – MONTHLY BILLING PLAN***

$6.00 added monthly to my city utility (water) bill for 12 months (=$72.00 per year). A 5% late fee will be assessed to all past due accounts.

☐ **OPTION III – ANNUAL BILLING PLAN***

$59.00 added to my January city utility (water) bill for a one-time payment in full. January payment must be paid by due date or your EMS LIFELINE membership will be canceled.

☐ **OPTION IV**

I am enclosing my credit card information and allowing a payment of $59.00 to be charged to renew my Lifeline membership for January 1, 2017-December 31,2017.

Signature _____

Card Number ☐☐☐☐–☐☐☐☐–☐☐☐☐–☐☐☐☐ VISA mastercard

Expiration Date ☐☐–☐☐ **Security Code** ☐☐☐ (Your security code is the three digit number on the back of you credit card)

Month Year

AGREEMENT – THIS IS NOT AN APPLICATION FOR AN INSURANCE POLICY

I hereby apply for membership with the Odessa Fire Rescue Emergency Medical Services Program. I understand that the enclosed annual fee of fifty–nine dollars ($59.00) (or $6.00 monthly) will cover myself, spouse, unmarried children under 26 years of age and any other qualified dependents as determined by the IRS and who may live at this address. I understand that through this membership, Odessa Fire Rescue Emergency Medical Services will provide emergency ambulance service within Ector County through Odessa Fire Rescue. **I also understand and give my permission for Odessa Fire Rescue Emergency Medical Services to bill my insurance and to obtain benefits, which are entitled through my insurance carriers.** This membership will cover the portion unreimbursed by my medical coverage for services rendered by Odessa Fire Rescue Emergency Medical Services during the time of my membership. If a person does not have health care insurance, this program covers emergency medical services delivered prior to hospital arrival.

I authorize the release of medical information for the purpose of billing my insurance. I understand that should I or a family member receive payment from insurance or any other medical provided for services rendered by Odessa Fire Rescue Emergency Medical Services, the payment will be immediately forwarded to Odessa Fire Rescue Emergency Medical Services to the extent necessary to satisfy any balance due.

I do understand that Odessa Fire Rescue Emergency Medical Services memberships are not solicited from persons who receive welfare medical benefits (Medicaid) and such memberships constitutes a voluntary contribution. I understand and agree that the EMS Service to be provided under this agreement is for a governmental service and the liability of the city, its employees and officials is to be governed solely by the Texas Tort Claims Act, Chapter 101, Texas Government Code. This agreement does not constitute a waiver or modification of such laws.

I understand Odessa Fire Rescue Emergency Medical Services provides ambulance transportation in true emergency cases only and not for transfer ambulance service. Violations of the terms of this agreement may result in immediate cancellation of my membership or other penalty. I also understand that this membership is non–refundable and non–transferable.

To The Insurance Company

I authorize a copy of this agreement to be used in lieu of the original on file at Odessa Fire Rescue Emergency Medical Services office. The original may be furnished on request. I authorize payment of insurance benefits for ambulance service for myself or family members directly to Odessa Fire Rescue Emergency Medical Services according to our agreement and as itemized on the attached claims. I have paid the co–payment for ambulance services to be rendered and expect your usual and customary ambulance reimbursement on my behalf to be sent to Odessa Fire Rescue Emergency Medical Services.

IMPORTANT: Must be signed to be valid.

_____ _____

MEMBER'S SIGNATURE
I have read the above and agree with the above.

SPOUSE'S SIGNATURE
I have read the above and agree with the above.

Application Deadline is December 31, 2016

For Additional Information, Call 257-0502