



A SERVICE OF THE ODESSA FIRE DEPARTMENT • Call 432-335-4653

Membership Application (Deadline: December 31, 2009)

COVERAGE PERIOD: January 1, 2010 through December 31, 2010

PLEASE PRINT (Complete in Full)

For office use only	
Membership #	
Utility Account #	
Date Received	
Check #	

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 (4) digits of your Social Security Number for verification purposes. List spouse, children under 25, 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 -	

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

MEMBER INSURANCE INFORMATION (In lieu of the following information, you may provide copies of both sides of insurance cards.)

MEDICARE INFORMATION

Medicare Number	Medicaid Number			
	Name	Address	Group/Policy #	Ins. SSN
Supplemental health insurance				
Other insurance				

INSURANCE INFORMATION

	Name	Address	Group/Policy #	Ins. SSN
Primary health insurance				
Other insurance				

SPOUSE INSURANCE INFORMATION

Medicare Information

Medicare Number	Medicaid Number			
	Name	Address	Group/Policy #	Ins. SSN
Supplemental Health Insurance				
Other insurance				

Insurance Information

	Name	Address	Group/Policy #	Ins. SSN
Primary health insurance				
Other insurance				

A new application must be filled out each year. Not valid unless signed on reverse side.

Other Dependent Insurance Information

Name of Insured _____

Medicare Number _____

Name	Address	Group #	Ins. SSN
------	---------	---------	----------

Primary health insurance _____

Other health insurance _____

Payment Options:

Option I - A check or money order in the amount of \$49.00 must accompany this application.

_____ I am enclosing a check or money order for \$49.00 to become a member of Lifeline (non-refundable).

Make check or money order payable to EMS LIFELINE and return to: EMS LIFELINE, P.O. Box 4398, Odessa, Texas 79760.

Option II - Monthly Billing Plan – You may choose to be billed \$5.00 each month (= \$60.00 per year) for 12 months on your city utility bill for Lifeline. This fee will automatically be added to your total monthly city utility bill beginning in Jan. and ending in Dec. Monthly billing does not require any initial fee or payment. You pay \$5.00 each month (= \$60.00 per year) on your city utility bill and you are protected by Lifeline as long as your payments are current. Please notify the Odessa Fire Department if your water service is discontinued in order to make other payment arrangements.

_____ Yes, I would like monthly billing. By marking this line, you are agreeing to \$5.00 each month (= \$60.00 per year) for 12-months beginning in Jan. and ending in Dec. on your city utility bill to be covered by Lifeline. A 5% late fee will be assessed to all past due accounts.

Billing Account Name: _____

AGREEMENT - THIS IS NOT AN APPLICATION FOR AN INSURANCE POLICY

I hereby apply for membership with the Odessa Fire Department Emergency Medical Services Program. I understand that the enclosed annual fee of forty-nine dollars (\$49.00) (or \$5.00 monthly) will cover myself, spouse, unmarried children under 25 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, the Odessa Fire Department Emergency Medical Service will provide emergency ambulance service within Ector County through the Odessa Fire Department. **I also understand and give my permission for the Odessa Fire Department 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 the Odessa Fire Department 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 provider for services rendered by the Odessa Fire Department Emergency Medical Services, the payment will be immediately forwarded to the Odessa Fire Department Emergency Medical Services to the extent necessary to satisfy any balance due.

I do understand that the Odessa Fire Department 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 the Odessa Fire Department Emergency Medical Services provides ambulance transportation in true emergencies 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 the Odessa Fire Department 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 the Odessa Fire Department Emergency Medical Services according to our agreement 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 the Odessa Fire Department Emergency Medical Services.

IMPORTANT: Must be signed to be valid.

MEMBER'S SIGNATURE

I have read the above and agree with the above

SPOUSES SIGNATURE

I have read the above and agree with the above