

600 Ranch Rd.
Reedsport, OR 97467
(541) 271-3750

APPLICATION FOR MEMBERSHIP

\$55

A Service of Lower Umpqua Hospital
ENROLLMENT LIMITED TO AUGUST AND SEPTEMBER

PLEASE PRINT (Head of Household)

LAST NAME _____ Telephone _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Mailing Address (if different than above) _____

City _____ State _____ Zip _____

List all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at home or dependents living in substitute care (nursing home, adult foster care) in the Lower Umpqua area. Please list any last name that is different than the name above.

Household Members Last Name (if different from Head of Household)	First Name	Middle Initial	Relationship to Head of Household	Date of Birth			Social Security No.
				Mo.	Day	Yr.	
Head of Household _____							
Spouse or Dependent _____							
Dependent _____							
Dependent _____							
Dependent _____							
Dependent _____							

Please answer the following insurance questions:

CHECK APPROPRIATE BOXES:

YES NO

Does anyone on your ParaMed membership have Medicare? YES NO

Medicare #: Head of Household: _____ Spouse: _____

Does anyone on your Paramed membership have medical insurance in addition to, or in place of Medicare? YES NO

Company _____ Group # _____ ID# _____

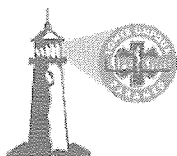
Does anyone on your ParaMed membership have automobile insurance? YES NO

Company _____ Policy # _____

ParaMed will bill your insurance and accept whatever it pays as payment-in-full according to the terms of agreement. Please read agreement carefully.

Please fill this form out completely, sign the signature form on the opposite side (all appropriate family members), and return this form along with the fee by September 30th or your application will be returned to you and membership will be declined.

PLEASE COMPLETE BOTH SIDES & RETURN WITH YOUR PAYMENT.



Lower Umpqua
PARAMED
LifeCare System

600 Ranch Rd.
Reedsport, OR 97467
(541) 271-3750

PARAMED LIFECARE AGREEMENT, SIGNATURE FORM, AND PAYMENT RECORD

PARAMED AGREEMENT

(Please read this statement carefully, then sign below.)

I hereby apply for membership in ParaMed LifeCare for myself and eligible members who live at my address. I understand the enclosed fee provides emergency ambulance care and transportation within the Lower Umpqua Hospital Emergency Medical Service service area, including transport to Bay Area Hospital or Lower Umpqua Hospital and non-emergency and long distance ambulance service as noted below. Coverage begins upon acceptance of this application and extends to September 30 of the following year. Non-emergency ambulance service to hospitals, 24-hour emergency medical receiving facilities, nursing homes and adult foster care centers within 35 miles is covered when medically necessary as determined by a doctor and with prior authorization from your insurance company if required by them. Long distance transports of over 35 miles are not covered but will be considered to have 25% of the co-payment prepaid by this membership agreement. I understand that ParaMed LifeCare is not insurance but will provide ambulance service through the Lower Umpqua Hospital EMS and will bill whatever insurance or medical benefits I may have and is entitled to primary and secondary insurance payment. ParaMed LifeCare is in excess of any insurance or medical benefits which I may have. I further authorize the release of medical information for the purpose of ambulance insurance billing only. Should I or a family member receive payment from insurance or other medical benefits provider for ambulance service rendered by Lower Umpqua Hospital EMS, I will immediately forward such payment to Lower Umpqua Hospital. ParaMed LifeCare membership is not solicited from persons who receive welfare medical benefits and such membership constitutes a voluntary contribution only. I understand that violations of the terms of this agreement may result in immediate cancellation. This membership is non-refundable and non-transferable.

*DEFINITION OF FAMILY

LifeCare membership covers immediate family members living in the same household. The member, spouse, unmarried children under age 25 and other persons listed as legal dependents for income tax purposes are covered. Others not included in this definition are required to obtain their own separate membership.

MEMBER BENEFITS IN AREAS OUTSIDE OF LOCAL LIFECARE SERVICE AREA

Member benefits are extended to areas outside of the local LifeCare service area but within the State of Oregon. These benefits are limited to the terms of agreement in effect by each individual ParaMed or FireMed participating agency at the time benefits are used. Members who receive ambulance service from any other ParaMed or FireMed participating agency are eligible for benefits offered by that agency provided that: 1) a copy of the ambulance bill is submitted to the local ParaMed LifeCare within 30 days of receipt of bill, 2) the member agrees to abide by the participating agency's terms of agreement. A current list of FireMed participating agencies is on file in the ParaMed LifeCare business office.

TO THE INSURANCE CARRIER

I authorize a copy of this agreement to be used in lieu of the original on file at the ParaMed LifeCare office. The original may be furnished on request. I authorize payment of insurance benefits for ambulance service for myself or family members directly to Lower Umpqua Hospital ParaMed, according to the LifeCare agreement and as itemized on the attached claims. I have paid the co-payment for ambulance service to be rendered and expect your usual and customary ambulance reimbursement on my behalf to be sent directly to the Lower Umpqua Hospital.

This form must be signed by all persons in the household covered by this membership 18 years of age and older.

Head of Household _____
(Signature)

Spouse _____ (Signature) Dependent _____ (Signature)

Dependent _____ (Signature) Dependent _____ (Signature)

Dependent _____ (Signature) Dependent _____ (Signature)

**A check, money order or credit card information must accompany this application.
Please make check payable to Lower Umpqua Paramed.**

I have enclosed payment by:

() Money Order () Cash

() Check Visa Card # _____ / _____ / _____ / _____ Expiration date _____ / _____

() Credit card Master Card # _____ / _____ / _____ / _____ Expiration date _____ / _____

YOUR CANCELLED CHECK, CREDIT CARD STATEMENT OR MONEY ORDER RECEIPT IS PROOF OF MEMBERSHIP.

PLEASE COMPLETE BOTH SIDES & RETURN WITH YOUR PAYMENT.